SERFF Tracking Number:	*CLTR-127669531*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49949*
Company Tracking Number:	*AH 100A ADD AR F*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*AD&D*		
Project Name/Number:	*Group AD&D Filing/*		

Filing at a Glance

Company: Atlantic Specialty Insurance Company

Product Name: AD&D	SERFF Tr Num: CLTR-127669531	State: Arkansas
TOI: H03G Group Health - Accidental Death & Dismemberment	SERFF Status: Closed-Approved	State Tr Num: 49949
Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment	Co Tr Num: AH 100A ADD AR F	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Donna Lambert
	Authors: Stephanie Young, Linda Ryan-James, Mark Swercheck, Wendy Hicks, Dana Suter	Disposition Date: 11/10/2011
	Date Submitted: 10/05/2011	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date: 12/12/2011

State Filing Description:

General Information

Project Name: Group AD&D Filing	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 11/10/2011	
State Status Changed: 11/10/2011	Deemer Date:
Created By: Dana Suter	Submitted By: Wendy Hicks

Corresponding Filing Tracking Number: CLTR-125083112

Filing Description:

On behalf of Atlantic Specialty Insurance Company, Coulter and Associates is filing the attached Group Health Accidental Death and Dismemberment forms.

These forms were previously filed and approved for OneBeacon America Insurance Company and the only changes to the forms are the company name, form number and edition date.

SERFF Tracking Number:	*CLTR-127669531*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49949*
Company Tracking Number:	*AH 100A ADD AR F*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*AD&D*		
Project Name/Number:	*Group AD&D Filing/*		

These forms were approved for OneBeacon America Insurance Company on 02/05/2007 in SERFF Tracking Number CLTR-125083112.

As with the OneBeacon America Insurance Company filing and approval previously referenced, bracketed language is either included or deleted and not amended within the brackets. Numerical data will continue to comply with state minimum requirements.

The forms/rates will become effective upon approval.

If you have any questions, please call me at (609) 443-7540 or email me at stephaniey@coulter-and-associates.com. Otherwise we look forward to your approval.

Company and Contact

Filing Contact Information

Stephanie Young, Consultant
C/O Coulter-and-associates.com
379 Princeton-Hightstown Rd
Suite 15
Cranbury, NJ 08512

stephaniey@coulter-and-associates.com
609-443-7540 [Phone]
609-443-4103 [FAX]

Filing Company Information

(This filing was made by a third party - coulterandassociatesinc)

Atlantic Specialty Insurance Company
One Beacon Lane
Canton, MA 02021
(212) 428-6580 ext. [Phone]

CoCode: 27154
Group Code:
Group Name:
FEIN Number: 13-3362309

State of Domicile: New York
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$450.00
Retaliatory?	No
Fee Explanation:	8 Forms @ $50 = $400 1 application @ $50 = $ 50

SERFF Tracking Number:	*CLTR-127669531*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49949*
Company Tracking Number:	*AH 100A ADD AR F*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*AD&D*		
Project Name/Number:	*Group AD&D Filing/*		
Per Company:	No		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Atlantic Specialty Insurance Company	$450.00	10/05/2011	52493743

SERFF Tracking Number:	*CLTR-127669531*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49949*
Company Tracking Number:	*AH 100A ADD AR F*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*AD&D*		
Project Name/Number:	*Group AD&D Filing/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	11/10/2011	11/10/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Donna Lambert	10/11/2011	10/11/2011	Wendy Hicks	11/09/2011	11/09/2011

SERFF Tracking Number:	*CLTR-127669531*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49949*
Company Tracking Number:	*AH 100A ADD AR F*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*AD&D*		
Project Name/Number:	*Group AD&D Filing/*		

Disposition

Disposition Date: 11/10/2011
Implementation Date: 12/12/2011
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CLTR-127669531*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49949*
Company Tracking Number:	*AH 100A ADD AR F*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*AD&D*		
Project Name/Number:	*Group AD&D Filing/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Authorization	Approved	Yes
Supporting Document	Certification	Approved	Yes
Form *(revised)*	Group Accident Policy	Approved	Yes
Form *(revised)*	Group Accident Certificate	Approved	Yes
Form	Group Accident Policy	Replaced	Yes
Form	Group Accident Certificate	Replaced	Yes
Form	Insurance Binder	Approved	Yes
Form	Hazards Endorsement	Approved	Yes
Form	Premium Refund Endorsement	Approved	Yes
Form	Extension of War Risk Extension Endorsement	Approved	Yes
Form	Portability Coverage Certificate Endorsement	Approved	Yes
Form	Administrative Change Endorsement	Approved	Yes

SERFF Tracking Number:	*CLTR-127669531*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49949*
Company Tracking Number:	*AH 100A ADD AR F*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*AD&D*		
Project Name/Number:	*Group AD&D Filing/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/11/2011
Submitted Date	10/11/2011
Respond By Date	

Dear Stephanie Young,

This will acknowledge receipt of the captioned filing.

ACA 23-86-106 defines eligible groups. No product can be marketed to an association, including a labor union, unless the requirements of 23-86-106(2) are met. Each must be filed with and approved by the Department.

Please give us your assurance that no product will be marketed to any association or labor union unless first filed with and approved by the Department.

Objection 1

- Group Accident Policy, AH 100A GA CW (Form)
- Group Accident Certificate, AH 102A GA CW (Form)

Comment: 1. Please add a provision to comply with 23-86-108(3).

2. Your exclusion of the use or release of explosives, nuclear energy, etc., appears to be another way to define terrorism. Our Department will not approve exclusions for terrorism or other terrorism-type language in life or accident and health contracts. Please remove this exclusion.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

SERFF Tracking Number:	*CLTR-127669531*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49949*
Company Tracking Number:	*AH 100A ADD AR F*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*AD&D*		
Project Name/Number:	*Group AD&D Filing/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/09/2011
Submitted Date	11/09/2011

Dear Donna Lambert,

Comments:
The information and attachments provided are responses to Objection items listed below.

Please note that the Policy and Certificate have been replaced with revised documents. The original forms were Country Wide (CW) and not state specific. Consequently, the "Leading Form Number" represented in this filing is the CW form number. The "Lead Form Number representing the revised Policy is AH 100A GA AR 08 11.

We assure the state that we will not market this product to any association or labor union unless we have first filed with and received approval from the Arkansas Department.

Response 1

Comments: With regard to objection #1, this provision can be found on page 4 of the policy in the “Effective Date B. For eligible individuals hired on or after [January 1, 2007]:” section, as well as on page 47 in the “Newly Acquired Corporation” section.

With regard to objection #2, we have deleted the referenced exclusion.

Related Objection 1

Applies To:

- Group Accident Policy, AH 100A GA CW (Form)
- Group Accident Certificate, AH 102A GA CW (Form)

Comment:

1. Please add a provision to comply with 23-86-108(3).

2. Your exclusion of the use or release of explosives, nuclear energy, etc., appears to be another way to define terrorism. Our Department will not approve exclusions for terrorism or other terrorism-type language in life or accident and health contracts. Please remove this exclusion.

Changed Items:

SERFF Tracking Number:	*CLTR-127669531*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49949*
Company Tracking Number:	*AH 100A ADD AR F*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*AD&D*		
Project Name/Number:	*Group AD&D Filing/*		

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Accident Policy	AH 100A GA AR 08 11		Policy/Contract/Fraternal Certificate	Initial		0.000	Revised ASIC 100A AR GA CW Policy 11.9.11.pdf
Previous Version							
Group Accident Policy	*AH 100A GA CW*		*Policy/Contract/Fraternal Certificate*	*Initial*		*0.000*	ASIC 100A GA CW Policy.pdf
Group Accident Certificate	AH 102A GA AR 08 11		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		0.000	ASIC 102A GA CW Certificate.pdf,Revised ASIC 102A AR GA CW Certificate 11.9.11.pdf
Previous Version							
Group Accident Certificate	*AH 102A GA CW*		*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider*	*Initial*		*0.000*	ASIC 102A GA CW Certificate.

SERFF Tracking Number:	*CLTR-127669531*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49949*
Company Tracking Number:	*AH 100A ADD AR F*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*AD&D*		
Project Name/Number:	*Group AD&D Filing/*		

pdf

No Rate/Rule Schedule items changed.

We look forward to your reply.

Sincerely,
Dana Suter, Linda Ryan-James, Mark Swercheck, Stephanie Young, Wendy Hicks

SERFF Tracking Number:	*CLTR-127669531*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49949*
Company Tracking Number:	*AH 100A ADD AR F*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*AD&D*		
Project Name/Number:	*Group AD&D Filing/*		

Form Schedule

Lead Form Number: AH 100A GA CW

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 11/10/2011	AH 100A GA AR 08 11	Policy/Contract/Fraternal Certificate	Group Accident Policy	Initial		0.000	Revised ASIC 100A AR GA CW Policy 11.9.11.pdf
Approved 11/10/2011	AH 102A GA AR 08 11	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Group Accident Certificate	Initial		0.000	ASIC 102A GA CW Certificate.pdf Revised ASIC 102A AR GA CW Certificate 11.9.11.pdf

GROUP [BASIC][BUSINESS TRAVEL][VOLUNTARY] ACCIDENT POLICY

FOR

[POLICYHOLDER]

THIS POLICY PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY.

IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS.

This Policy is a Legal Contract between the Policyholder and the Insurer.

Please read this Policy carefully.

[Atlantic Specialty Insurance Company]
[1 Beacon Lane
Canton, MA 02021-1030]

POLICYHOLDER:	**[ABC Company]** **[123 Street]** **[Anycity, YZ 12345]**
POLICY NUMBER:	**[1234567]**
POLICY EFFECTIVE DATE:	**[January 1, 2007]**
[POLICY EXPIRATION DATE:	**[January 1, 2008]]**
[POLICY ANNIVERSARY DATE:	**[January 1st]]**
[COVERED SUBSIDIARIES OR AFFILIATED COMPANIES:	**[Names of Companies]]**

This Policy is a legal contract between the Policyholder and the Insurer. The Insurer agrees to insure eligible persons of the Policyholder, for whom premium is paid, against loss covered by this Policy, subject to its provisions, limitations and exclusions.

This Policy takes effect on the Policy Effective Date. All periods of insurance begin and end when 12:01 AM, Standard Time occurs at the Policyholder's address. This Policy remains in force for the period for which premium has been paid.

This Policy is governed by the laws of the state in which it is delivered.

In Witness Whereof, We have caused this Policy to be executed and attested, and, if required by state law, this Policy shall not be valid unless countersigned by our authorized representative.

Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company

Michael Miller, President & CEO
Atlantic Specialty Insurance Company

Countersigned _____
Authorized Representative Date

GROUP ACCIDENTAL DEATH & DISMEMBERMENT POLICY

Table of Contents

SECTION I – ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

PRIMARY INSURED PERSON.

Eligibility. The following individuals are eligible to become **Primary Insured Persons** upon [completion of the **Service Waiting Period** indicated below, and] the submission of completed enrollment materials, if required:

Class	Description
[1]	[All **Active** [full-time][and part-time]employees of the **Policyholder** working a minimum of [30] hours per week.]
[2]	[All **Active** [Union][non-Union] employees of the **Policyholder**.]
[3]	[As determined by the **Policyholder's** written human resource policy for benefit eligibility, with respect to Accident coverage, as of the effective date of this **Policy**.]

[If a **Primary Insured Person** sustains an **Injury** resulting in a **Covered Loss**, and he or she is covered under more than one Class, only one benefit will be paid, the largest benefit.]

Effective Date. [A. For eligible individuals hired prior to [January 1, 2007]:
[January 1, 2007], provided the completed enrollment material is received by the **Policyholder** on or prior thereto.

B. For eligible individuals hired on or after [January 1, 2007]:
[on the first day of the month following the date the completed enrollment material is received by the **Policyholder**] [upon completion of the required **Service Waiting Period** indicated below, provided the completed enrollment material is received by the **Policyholder** prior thereto] [on the first day of the month following completion of the required **Service Waiting Period** indicated below, provided the completed enrollment material is received by the **Policyholder** prior thereto].]

[A. For eligible individuals hired prior to [January 1, 2007]:
the later of the **Policy** effective date or upon completion of the required **Service Waiting Period**, if any, indicated below.

B. For eligible individuals hired on or after [January 1, 2007]:
the later of their first day of **Active** work or upon completion of the required **Service Waiting Period**, if any, indicated below.]

[A. For eligible individuals hired prior to [January 1, 2007]:
their first day of **Active** work following the effective date of the **Policy**.

B. For eligible individuals hired on or after [January 1, 2007]:
their first day of **Active** work following their date of hire.]

[If the eligible individual is not **Actively at Work** on his or her Effective Date of coverage, coverage will begin on his or her first full day of **Active** work following his or her Effective Date.]

[Service Waiting Period. [None.] [[30] days of **Active** continuous service.][As per the **Policyholder's** then written plan.]]

Termination Date. [Coverage terminates at the end of the [month][period] for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;

2. the **Primary Insured Person** ceases to be eligible for coverage;

3. the **Primary Insured Person** fails to pay the required premium, if so required[;][.]

4. [the **Primary Insured Person** reaches age [70]][;][.]

5. [the **Primary Insured Person** retires.]]

[Coverage automatically terminates on the earliest of:

1. the date the **Policy** is terminated;

2. the date the **Primary Insured Person** ceases to be eligible for coverage;

3. the expiration date of the period for which required premium has been paid for such **Primary Insured Person**;

4. the date the **Primary Insured Person** fails to pay the required premium, if so required[;][.]

5. [the date the **Primary Insured Person** reaches age [70]][;][.]

6. [the date the **Primary Insured Person** retires.]]

[If a **Primary Insured Person** has received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written policy, his or her insurance under this **Policy** will continue, provided the required premiums are paid. This extension of coverage is subject to all of the termination provisions of this **Policy** with the exception of number 2. above.]

[**Conversion Coverage**

If the insurance of a **Primary Insured Person** ceases for reasons other than termination of the **Policy** [or nonpayment of premium], the **Primary Insured Person** is entitled to purchase **Conversion Coverage** under a conversion group policy. [The **Primary Insured Person** may also purchase **Conversion Coverage** for his or her **Dependents**, if such **Dependents** were covered under this **Policy** at the time insurance ceases.] The conversion group policy will be on **Our** approved forms and will only provide **Accidental Death Benefits** [and **Accidental Dismemberment** [and **Covered Loss of Use**][and **Plegia**] **Benefits**].

Written application for **Conversion Coverage** must be made within [sixty (60)] days of the cessation of insurance under this **Policy**. [To request an application form, the **Primary Insured Person** must [call [1-800-527-1255]] [or write to **Us** at [44 Whippany Road, Morristown, NJ 07960]].] The **Primary Insured Person** [and/or **Insured Person**, if applicable,] is not required to show proof of good health.

The issuance of **Conversion Coverage** is subject to the following conditions:

1. the **Principal Sum** will be the lesser of:

- **a.** the **Primary Insured Person's Principal Sum** under this **Policy** [, rounded to the next higher [$10,000], if not already a multiple thereof,] [, but the amount may not be less than [$50,000].] [In the event that the **Primary Insured Person** has a **Principal Sum** in an amount less than [$100,000], he or she may continue that amount or increase the amount to [$100,000].][;] Or,
- **b.** [$250,000];

2. the premium for the group conversion policy will be the rate on file with the proper regulatory authority, if such filing is required;

3. coverage under the conversion group policy will take effect on the termination date of the **Primary Insured Person's** coverage under this **Policy**; and

4. when coverage under the conversion group policy becomes effective, the relationship between the **Primary Insured Person** and **Us** will be governed by that policy, including all terms and conditions, and benefits and termination dates.

[Eligibility for **Conversion Coverage** will cease when the **Primary Insured Person** attains age [seventy (70)].]

[**Conversion Coverage** is only available to those **Primary Insured Persons** who are residents of the United States at the time **Conversion Coverage** is purchased.]

[**Conversion Coverage** is [not] available for residents of [named states].]

[**Covered Loss During the Conversion Coverage Application Period**. If the **Primary Insured Person** sustains an **Injury** resulting in a **Covered Loss** that would have been payable under the **Accidental Death Benefit [or Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, within the [sixty (60] day **Conversion Coverage** application period, **We** will pay the **Principal Sum** amount that would have been paid under this **Policy**. This benefit will be paid regardless of whether the **Primary Insured Person** had applied to purchase **Conversion Coverage** at the time of his or her **Covered Loss**.]]

[**Portability Coverage**

If the insurance of a **Primary Insured Person** ceases for reasons other than [non-payment of premium or] cancellation of this **Policy**, he or she has the right to continue **Coverage** under this **Policy**, [even if this **Policy** is subsequently canceled or terminated for any reason] [provided the **Policy** is not subsequently canceled or terminated.]

This **Portability Coverage** is subject to the following conditions:

1. written notice to **Us** of the **Primary Insured Person's** election to continue **Coverage** and the initial premium, must be received by **Us** within [sixty (60)] days of the event causing the termination of the individual's insurance, along with the **Primary Insured Person's** home and billing address, if different.

2. the **Primary Insured Person** may elect to continue the same **Principal Sum** [rounded up to the next higher [$10,000]] [to a maximum of [$250,000]][but the amount may not be less than [$50,000]]. In the event that the **Primary Insured Person** has a **Principal Sum** in an amount less than [$100,000], he or she may continue that amount or increase the amount to [$100,000]. [The maximum **Principal Sum** under this **Portability Coverage** will be [$250,000.]]

3. upon receipt of the written notice, **We** will provide the **Primary Insured Person** with a **Certificate** Endorsement to be attached to his or her **Certificate of Insurance**, which will provide the Initial **Portability Coverage** Period beginning with the termination date of the **Primary Insured Person's** coverage under this **Policy**.

4. the initial premium will be based upon the Portability rates which appear in the Premium Section of this **Policy**. [**We** reserve the right to change the premium.]

[Eligibility for **Portability Coverage** will cease when the **Primary Insured Person** attains age [seventy (70)].]

[If the insurance of a **Covered Spouse [/Domestic Partner]** ceases because of the death of the **Primary Insured Person** while **Portability Coverage** is in effect, the **Covered Spouse [/Domestic Partner]** may apply to continue **Portability Coverage**. The **Covered Spouse [/Domestic Partner**] will be eligible for the amount of **Principal Sum** he or she had in force under the **Portability Coverage**. Written application for continuation of **Portability Coverage** must be made within [sixty (60)] days of the cessation of the **Covered Spouse's [/Domestic Partner's**] insurance under **Portability Coverage**.]

[**Portability Coverage** is [only] available for residents of [named states].]

[**Covered Loss During the Portability Coverage Application Period**. If the **Primary Insured Person** sustains an **Injury** resulting in a **Covered Loss** that would have been payable under the **Accidental Death Benefit [or Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, within the [sixty (60] day **Portability Coverage** application period, **We** will pay the **Principal Sum** amount that would have been paid under this **Policy**. This benefit will be paid regardless of whether the **Primary Insured Person** had applied to purchase **Portability Coverage** at the time of his or her **Covered Loss**.]]

[PRIMARY INSURED PERSON'S DEPENDENTS.

Eligibility. Individuals who enroll may elect to cover their eligible **Dependents**. An eligible **Dependent** includes the **Primary Insured Person's Spouse**[/**Domestic Partner**] and the **Primary Insured Person's Dependent Child(ren)**, [and] [his or her **Spouse's Dependent Child(ren)]** [, and his or her **Domestic Partner's Dependent Child(ren)**]. [A **Spouse**[/**Domestic Partner**] will not be eligible as a **Dependent** if he or she is also a **Primary Insured Person** under this **Policy**.] [If the **Primary Insured Person** and his or her **Spouse [/Domestic Partner]** or former **Spouse**[/**Domestic Partner**] are both **Primary Insured Person's** under this **Policy**, only one may select a **Plan** covering their mutual **Dependents**.]

Effective Date. Dependent coverage begins on the later of:

1. the date the **Primary Insured Person's** coverage begins, provided the **Primary Insured Person** has requested **Dependent Coverage** on his or her enrollment materials;

2. the date the **Primary Insured Person** requests to add coverage for his or her eligible **Dependents** in the applicable benefit materials; or

3. the date he or she becomes an eligible **Dependent**.

Termination Date. [Coverage terminates at the end of the [month][period] for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;

2. the **Dependent** ceases to be eligible for insurance;

3. the coverage of the **Primary Insured Person** terminates, except in such situations where the written policy of the **Policyholder** allows such **Primary Insured Person** to continue coverage for his or her **Covered Dependents**;

4. the **Primary Insured Person** fails to pay the required premium, if so required[;][.]
5. [for the **Covered Spouse**[/**Domestic Partner**] only, the **Covered Spouse[/Domestic Partner** reaches age [70].]]

[Coverage automatically terminates on the earliest of:

1. the date the **Policy** is terminated;
2. the date the **Dependent** ceases to be eligible for coverage;
3. the date the coverage of the **Primary Insured Person** terminates, except in such situations where the written policy of the **Policyholder** allows such **Primary Insured Person** to continue coverage for his or her **Covered Dependents**;
4. the expiration date of the period for which required premium has been paid for such **Dependent**;
5. the date the **Primary Insured Person** fails to pay the required premium, if so required[;][.]
6. [for the **Covered Spouse[/Domestic Partner**]only, the date the **Covered Spouse[/Domestic Partner** reaches age [70].]]

[If a **Primary Insured Person** has received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written policy, insurance for his or her **Covered Dependents** under this **Policy** may continue, provided the required premiums are paid. This extension of coverage is subject to all of the termination provisions of this **Policy** with the exception of number 2. above.]

[Notwithstanding the forgoing provisions, this **Policy** will conform to the **Policyholder's** written policy with respect to accident coverage with regard to eligibility for coverage, continuation of coverage, and termination of coverage as in force on the effective date of this **Policy**. [The **Policyholder's** written policy must be on file with **Us**.] [If the **Policyholder's** written policy is not on file with **Us**, this **Policy** will govern.]]

SECTION II – SCHEDULE

HAZARDS

The following are the **Hazards** for which insurance applies:

[All Classes]	[including their **Covered Dependents**]:]
	[24 Hour **Accident** Protection, Business and Pleasure, Excluding Corporate Owned or Leased Aircraft]
[Class 1]	[and their **Covered Dependents**]:] [24 Hour **Accident** Protection while on a **Specified Trip**]

Additional Coverages

[Class 2]	[and their **Covered Dependents**]:]	[Felonious Assault Coverage]

BENEFITS

A. Principal Sum

The following are the **Principal Sums** for each Class:

[Class 1]	[An employee may purchase an amount of **Principal Sum** from a minimum of [$50,000] to a maximum of [$500,000] in increments of [$10,000]. [However, amounts applied for in excess of [$150,000] must not exceed [ten (10)] times the employee's **Base Annual Earnings***.]]
[Class 2]	[[Three (3)] times the employee's **Base Annual Earnings*** to a maximum of [$500,000].]
[Class 3]	[$100,000]

[Class 4] [as on file with the **Policyholder** and **Us**]

[*__Base Annual Earnings__ means the employee's base annual pay [excluding overtime, bonuses, [commissions] and special compensation.]]

[The following are the **Principal Sums** for **Covered Dependents**:

[The **Principal Sum** for **Covered Dependents** will be a percentage of the employee's **Principal Sum**:

Plan Selected	**% Spouse[/Domestic Partner]**	**% Child(ren)**
Spouse[**/Domestic Partner**] only:	[50%]	0
Dependent Child(ren) only:	0	[15%]
Spouse[/Domestic Partner] and **Dependent Child(ren)**	[40%]	[10%]

[Maximum of [$25,000] [**Principal Sum**] [**Accidental Death Benefit**] for **Dependent Child(ren)**.]

[For **Covered Dependent Child(ren)** the indicated percentage applies to loss of life only.]

[In no event will the amount be greater than the **Primary Insured Person's Principal Sum**.]]

[The **Principal Sum** for **Covered Dependents** will be [a choice of] the following amounts:

Spouse[**/Domestic Partner**]: [$50,000] [$75,000] [$100,000]

Dependent Child(ren): [$10,000] [$15,000] [$20,000] [$25,000]

[In no event will the amount be greater than the **Primary Insured Person's Principal Sum**.]]

[Principal Sum Reduction

[At age [70], [for the **Primary Insured Person** only,] the **Principal Sum** will be reduced based on the [**Primary Insured Person's**] [**Insured Person's**] previous **Principal Sum** per the following schedule:

Age at Date of Loss	**Percent of Principal Sum**
[70-74]	[65%]
[75-79]	[45%]
[80-84]	[30%]
[85 & Over]	[15%]]

[Aggregate Limit of Liability

[The **Aggregate Limit of Liability** per [air travel] **Covered Accident** is [$0.00].]

[The **Aggregate Limit of Liability** per [on-premises Felonious Assault Coverage,][On-Premises Terrorism Coverage,][War Risk Coverage,][on-premises Bomb Scare/Explosion Coverage] **Covered Accident** [combined] is [$0.00].]]

[**Escalator Clause**

We will increase the **Accidental Death Benefit** for the **Primary Insured Person** at an amount equal to [2%] of the **Primary Insured Person's Principal Sum** for each year the **Primary Insured Person** remains continuously covered under this **Policy** for a maximum of [five (5)] years. [If the **Primary Insured Person** selected a **Plan** covering his or her **Dependent(s)**, the **Principal Sum** for his or her **Covered Dependent(s)** will be calculated from the **Primary Insured Person's** original **Principal Sum**, and therefore this increase does not affect the **Covered Dependent's Accidental Death Benefit(s)**.]

The first increase will take effect one year from the **Policy** anniversary date that is equal to or later than the date the **Primary Insured Person** became eligible for benefits under this **Policy**. Future increases will take effect on subsequent **Policy** anniversary dates. The increase will be based on the **Primary Insured Person's Principal Sum** on the day immediately prior to the **Policy** anniversary date.]

B. Accidental Death Benefit

This benefit applies to [all Classes of **Primary Insured Persons** [and their **Covered Dependents**]] **[**Class 1 [and their **Covered Dependents**]] [Classes 2 and 3 [and their **Covered Dependents**]].

C. [Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Benefit

This benefit applies to [all Classes of **Primary Insured Persons** [and their **Covered Dependents**]] **[**Class 1 [and their **Covered Dependents**]] [Classes 2 and 3 [and their **Covered Dependents**]].

D. [Coma Benefit]

This benefit applies to [all Classes of **Primary Insured Persons** [and their **Covered Dependents**]] **[**Class 1 [and their **Covered Dependents**]] [Classes 2 and 3 [and their **Covered Dependents**]].

E. [Additional Benefits

[All Classes [including their **Covered Dependents**]:]	[Seat Belt Benefit]
	[Rehabilitation Benefit]
	[Accident Weekly Indemnity Benefit]
[Class 1 [and their **Covered Dependents**]:]	[Accident Medical Benefit]]

[ENDORSEMENTS

The following Endorsements have been attached to and are included in this **Policy** effective [January 1, 2007]:

[Administrative Change Endorsement] [Endorsement No. [1]] [XX 12345] [for: Class 2]]

SECTION III – PREMIUM

Premium Due Date: [15th day of month following month of coverage] [First day of each month] [Effective date of **Policy**] [as indicated below]

Premium Amount:

[Employee Only:	[$0.000] per $[1,000] of **Principal Sum** per month]
[**Spouse**[**/Domestic Partner**] Only:	plus [$0.000] per $[1,000] of **Principal Sum** per month]
[**Dependent Children** Only:	plus [$0.000] per $[1,000] of **Principal Sum** per month]
[Employee & **Dependents**:	[$0.000] per $[1,000] of **Principal Sum** per month]
[Portability Coverage - Employee Only:	[$0.00] annual premium]
[Portability Coverage - Employee & **Dependents**:	[$0.00] annual premium]
[Annual Premium Option:	[$10,000]]
[Multiple Years Option:	[$150,000] [three] year term premium payable in equal annual installments of: [$50,000] due [January 1, 2007] [$50,000] due [January 1, 2008] [[$50,000] due [January 1, 2009]]]
[Multiple Years Prepaid Option:	[$150,000] [three] year term premium payable in advance]
[Additional Specified Pilot Coverage Premium:	[$0.00] per [$1,000] of **Principal Sum** per month while a pilot, operator, crew member or cabin attendant]
[War Risk Coverage Premium:	[included in Premium stated above][$50,000] [[$5,000] per [month]]]

[Guarantee: [These rates are][This **Policy** is] guaranteed until [January 1, 2009].]
[These rates and this **Policy** are guaranteed until [January 1, 2009].]]

Grace Period. Premiums are due for this **Policy** on or before the premium due date. If the **Policyholder** does not pay a premium when it is due, there is a [thirty-one (31)] day **Grace Period** to pay. During the **Grace Period**, the **Policy** will stay in force. The **Policyholder** will be liable for payment of the premium for the time this **Policy** remains in force during the **Grace Period**, unless proof is provided to **Us** that this **Coverage** has been replaced during such period. The **Policyholder** will not have a **Grace Period** if **We** have given written notice, at least [thirty (30)] days in advance, that **We** are going to terminate this **Policy**, or if **We** receive written notice, at least [thirty (30)] days in advance, to terminate this **Policy** prior to a premium due date.

[**Waiver of Premium**

If a **Primary Insured Person** [is] [becomes] **Totally Disabled** while covered under this **Policy**, **We** will waive the premium due for him or her under this **Policy**, provided the disability has continued for a period greater than [six (6)] consecutive months.

Premium payments will continue for the first [six (6)] months of continuous **Total Disability**. [However, credit toward the first [six (6)] months of continuous, **Total Disability** will be given if the **Primary Insured Person** was **Totally Disabled** under the **Policy** that **We** have replaced.] After this [six (6)] month period of continuous **Total Disability**, the **Primary Insured Person's** premium for this **Policy** will be waived until the earliest of the following:

1. the **Primary Insured Person** is no longer **Totally Disabled** because of the **Injury**;

2. the **Policy** terminates;

3. the employment of the **Primary Insured Person** terminates;

4. [the **Primary Insured Person** attains age [70]].

For purposes of this waiver, **Totally Disabled** means that the **Primary Insured Person** is: 1) unable to perform the substantial and material duties of his or her regular occupation; and 2) attended to, on a regular basis, by a duly licensed **Physician**, other than the **Primary Insured Person** or a member of his or her immediate family.

To apply for this waiver, the **Policyholder** will notify **Us** in writing of the **Primary Insured Person's Total Disability** and request a **Waiver of Premium Form** and a **Disability Claim Form**. These forms must be completed by the **Policyholder**, the **Primary Insured Person** and the attending **Physician**, and mailed to the Claims Department, Atlantic Specialty Insurance Company, [44 Whippany Road, Morristown, NJ 07960].]

SECTION IV – HAZARDS

[**24 HOUR ACCIDENT PROTECTION, BUSINESS AND PLEASURE**
[EXCLUDING] [INCLUDING] CORPORATE OWNED OR LEASED AIRCRAFT,
[AND SUBSTITUTE AIRCRAFT,]
[PASSENGER ONLY] [PASSENGER AND CREW]

This **Policy** insures against the following **Hazards**:

A **Covered Injury** sustained by [a **Primary Insured Person**] [an **Insured Person**][anywhere in the world], subject to the terms, conditions, exclusions and limitations under this **Policy**.

[Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a trip, while the [**Primary Insured Person**] [**Insured Person**] is [a passenger,] [pilot, operator, member of the crew or cabin attendant,] riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:

a. medical certificate; and

b. pilot certificate with a proper rating to pilot such aircraft.

2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.]

[Hazard Exclusions:

Coverage is not provided:

1. [If the [**Primary Insured Person]**[**Insured Person**] is the pilot, operator, member of the crew or cabin attendant of any aircraft [except those aircraft specified below].]

2. [Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:

a. [any aircraft other than those expressly stated in this **Hazard**;]

b. [any aircraft [**Owned** or] [**Controlled** by, or] [**Under lease** to] the **Policyholder**[;] [except the following aircraft, [including **Substitute Aircraft**]:

[Description of Aircraft]

provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least [1,000] hours as a pilot of which at least [500] hours were logged in this or the same class of aircraft.]]

c. [any aircraft **Owned** or **Controlled** by, or **Under lease** to [a **Primary Insured Person][**an **Insured Person]** [or a member of [a **Primary Insured Person's**][an **Insured Person's**] [family or] household];]

d. [any aircraft operated by [the **Policyholder** [except those indicated in b. above, [including **Substitute Aircraft**]]or] one of the **Policyholder's** employees [including members of an employee's [family or] household];]

e. [any aircraft engaged in a **Specialized Aviation Activity**;**]**

f. [any conveyance [except aircraft] used [for tests or experimental purposes, [or]] [in a race or speed test].]]]

[**Hazard Definitions:**

[**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:

1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;

2. is the same class of aircraft as the specified aircraft; and

3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.]]

[**Note**: A complete updated list of all Corporate Aircraft must be provided to **Us** on each anniversary of the **Policy**.]

Other Limitations and Exclusions that apply to this **Hazard** are in Section VIII Limitations and Section IX General Exclusions.

H1-XX]

[24 HOUR ACCIDENT PROTECTION WHILE ON BUSINESS TRIP,
[EXCLUDING] [INCLUDING] CORPORATE OWNED OR LEASED AIRCRAFT,
[AND SUBSTITUTE AIRCRAFT,]
[PASSENGER ONLY] [PASSENGER AND CREW]

This Policy insures against the following **Hazards**:

A **Covered Injury** sustained by a **Primary Insured Person [**anywhere in the world] while on the **Business of the Policyholder** [during a business trip][and during a **Bona Fide Trip**], subject to the terms, conditions, limitations and exclusions under this **Policy**.

Coverage, subject to limitations and exclusions, is provided between:

1. the later of the time the **Primary Insured Person** leaves the place where he or she normally works or lives; and

2. the earlier of the time the **Primary Insured Person** returns to the place where he or she normally works or lives.

[Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a trip, while the **Primary Insured Person** is [a passenger,] [pilot, operator, member of the crew or cabin attendant,] riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
   a. medical certificate; and
   b. pilot certificate with a proper rating to pilot such aircraft.
2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.]

[Hazard Exclusions:

Coverage is not provided:

1. [If the **Primary Insured Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft [except those aircraft specified below].]
2. [For an assignment by the **Policyholder** or relocation that exceeds [sixty (60)] days in duration. Note: If an assignment exceeds [sixty (60)] days in duration, the location of the assignment will be considered the place of permanent assignment, and the **Primary Insured Person** will then have **Coverage** when traveling elsewhere on the **Business of the Policyholder**.]
3. [Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   a. **[**any aircraft other than those expressly stated in this **Hazard**;]
   b. [any aircraft [**Owned** or] [**Controlled** by, or] [**Under lease** to] the **Policyholder** [except the following aircraft, [including **Substitute Aircraft**]:

      [Description of Aircraft]

      provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least [1,000] hours as a pilot of which at least [500] hours were logged in this or the same class of aircraft.]]
   c. [any aircraft **Owned** or **Controlled** by, or **Under lease** to a **Primary Insured Person** [or a member of a **Primary Insured Person's** [family or]household];]
   d. [any aircraft operated by [the **Policyholder** [except those indicated in b. above, [including **Substitute Aircraft**]]or] one of the **Policyholder's** employees [including members of an employee's [family or] household];]
   e. [any aircraft engaged in a **Specialized Aviation Activity**;]
   f. [any conveyance [except aircraft] used [for tests or experimental purposes, [or]] [in a race or speed test].]]]

Hazard Definitions:

- **Business of the Policyholder** means an assignment by or at the direction of the **Policyholder** to further the business of the **Policyholder**. It does not include an **Accident** occurring during usual travel to and from work; bona fide leaves of absence or vacation [; or **Personal Deviations/Side Trips** of a personal nature]. [It does not include employees who are hired to operate a truck.] [It does include **Personal Deviations/Side Trips** of a personal nature.]
- [**Bona Fide Trip** means a trip that requires the **Primary Insured Person** to travel outside the limits of the city or municipality where he or she normally works.]
- [**Personal Deviations/Side Trips** means non-business activities and/or travel of a personal nature, undertaken while on the **Business of the Policyholder**, but unrelated to furthering the **Business of the Policyholder** that: 1) is incidental to the business trip; 2) would not have been taken if not for the business trip; [and] 3) is taken during the course of the business trip[.] [; and 4) is limited to [72 hours]].]
- [**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:
  1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;

2. is the same class of aircraft as the specified aircraft; and

3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.]

[**Note**: A complete updated list of all Corporate Aircraft must be provided to **Us** on each anniversary of the **Policy**.]

Other Limitations and Exclusions that apply to this **Hazard** are in Section VIII Limitations and Section IX General Exclusions.

H2-XX]

[24 HOUR ACCIDENT PROTECTION WHILE [ON A SPECIFIED TRIP][ATTENDING A SPECIFIED EVENT],
[EXCLUDING] [INCLUDING] CORPORATE OWNED OR LEASED AIRCRAFT,
[AND SUBSTITUTE AIRCRAFT,]
[PASSENGER ONLY] [PASSENGER AND CREW]

This **Policy** insures against the following **Hazards**:

A **Covered Injury** sustained by a **Primary Insured Person** during a specified [trip] [event], subject to the terms, conditions, limitations and exclusions under this **Policy**, during a specified [trip] [event] to:

[insert destination/description of trip]

Coverage, subject to limitations and exclusions, is provided between:

[**1.** the later of the time the **Primary Insured Person** leaves the place where he or she normally works or lives; and

2. the earlier of the time the **Primary Insured Person** returns to the place where he or she normally works or lives.]

[**1.** the time the **Primary Insured Person** arrives at the exact location of the specified [trip] [event] ; and

2. the time the **Primary Insured Person** leaves the exact location of the specified [trip] [event].]

[Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during the [trip] [event], while the **Primary Insured Person** is [a passenger,] [pilot, operator, member of the crew or cabin attendant,] riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:

a. medical certificate; and

b. pilot certificate with a proper rating to pilot such aircraft.

2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.]

[Hazard Exclusions:

Coverage is not provided:

1. [If the **Primary Insured Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft [except those aircraft specified below].]

2. [For travel or activities by the **Primary Insured Person**, which deviate from the requirements for [making the specified trip] [attending the specified event], or travel that is an extension of the specified [trip] [event]. [This includes **Personal Deviations/Side Trips** of a personal nature.] [This does not include **Personal Deviations/Side Trips** of a personal nature.]]

3. [Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:

a. [any aircraft other than those expressly stated in this **Hazard**;]

b. [any aircraft [**Owned** or] [**Controlled** by, or] [**Under lease** to] the **Policyholder** [except the following aircraft, [including **Substitute Aircraft**]:

[Description of Aircraft]

provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least [1,000] hours as a pilot of which at least [500] hours were logged in this or the same class of aircraft.]]

c. [any aircraft **Owned** or **Controlled** by, or **Under lease** to a **Primary Insured Person** [or a member of a **Primary Insured Person's** [family or]household];]

d. **[**any aircraft operated by [the **Policyholder** [except those indicated in b. above, [including **Substitute Aircraft**]]or] one of the **Policyholder's** employees [including members of an employee's [family or] household];]

e. [any aircraft engaged in a **Specialized Aviation Activity**;]

f. [any conveyance [except aircraft] used [for tests or experimental purposes, [or]] [in a race or speed test].]]]

[**Hazard Definitions:**

- [**Personal Deviations/Side Trips** means non-business activities and/or travel of a personal nature, undertaken while [on the specified trip] [attending the specified event], but unrelated to the specified [trip] [event] that: 1) is incidental to the specified [trip][event]; 2) would not have been taken if not for the specified [trip][event]; [and] 3) is taken during the course of the specified [trip][event][.] [; and 4) is limited to [72 hours]].]
- [**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:
  1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
  2. is the same class of aircraft as the specified aircraft; and
  3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.]]

[**Note**: A complete updated list of all Corporate Aircraft must be provided to **Us** on each anniversary of the **Policy**.]

Other Limitations and Exclusions that apply to this **Hazard** are in Section VIII Limitations and Section IX General Exclusions.]

H3-XX]

[FULL OCCUPATIONAL COVERAGE, [EXCLUDING] [INCLUDING] CORPORATE OWNED OR LEASED AIRCRAFT, [AND SUBSTITUTE AIRCRAFT,] [PASSENGER ONLY] [PASSENGER AND CREW]

This **Policy** insures against the following **Hazards**:

A **Covered Injury** sustained by a **Primary Insured Person [**anywhere in the world] while on or off the premises of the **Policyholder** performing the usual and customary duties of his or her regular occupation, or while on the **Business of the Policyholder** during a **Bona Fide Trip**, subject to the terms, conditions, limitations and exclusions under this **Policy**.

[Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a **Bona Fide Trip**, while the **Primary Insured Person** is [a passenger,] [pilot, operator, member of the crew or cabin attendant,] riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid, normal, transport or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. The aircraft must be operated by a pilot with a current and valid:

a. medical certificate; and

b. pilot certificate with a proper rating to pilot such aircraft.

2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.]

[Hazard Exclusions:

Coverage is not provided:

1. [If the **Primary Insured Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft [except those aircraft specified below].]
2. [Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   - **a.** [any aircraft other than those expressly stated in this **Hazard**;]
   - **b.** [any aircraft [**Owned** or] [**Controlled** by, or] [**Under lease** to] the **Policyholder** [except the following aircraft, [including **Substitute Aircraft**]:

     [Description of Aircraft]

     provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least [1,000] hours as a pilot of which at least [1,000] hours were logged in this or the same class of aircraft.]]
   - **c.** **[**any aircraft **Owned** or **Controlled** by, or **Under lease** to a **Primary Insured Person** [or a member of a **Primary Insured Person's** [family or] household];]
   - **d.** [any aircraft operated by [the **Policyholder** [except those indicated in b. above, [including **Substitute Aircraft**]]or] one of the Policyholder's employees [including members of an employee's [family or] household];]
   - **e.** [any aircraft engaged in a **Specialized Aviation Activity**;**]**
   - **f.** [any conveyance [except aircraft] used [for tests or experimental purposes, [or]] [in a race or speed test].]]]

Hazard Definitions:

- **Bona Fide Trip** means a trip that begins when the **Primary Insured Person** leaves the place where he or she normally works or lives (whichever last occurs) to go on the trip. It ends when the **Primary Insured Person** returns from the trip to the place where he or she normally works or lives (whichever occurs first).
- **Business of the Policyholder** means while on assignment by or at the direction of the **Policyholder** to further the **Business of the Policyholder**. It does not include an **Injury** sustained during:
  1. usual travel to and from work;
  2. leaves of absence or vacations[.] [; or
  3. [**Personal Deviations/Side Trips** of a personal nature, during a **Bona Fide Trip**, that are not at the direction of and in furtherance of the economic interest of the **Policyholder**.]

  [It does not include employees who are hired to operate a truck.]

  [It does include **Personal Deviations/Side Trips** of a personal nature.]
- **[Personal Deviations/Side Trips** means non-business activities and/or travel of a personal nature, undertaken while on the **Bona Fide Trip**, but unrelated to the **Bona Fide Trip** that: 1) is incidental to the **Bona Fide Trip**; 2) would not have been taken if not for the **Bona Fide Trip**; [and] 3) is taken during the course of the **Bona Fide Trip**[.] [; and 4) is limited to [72 hours]].]
- [**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:
  1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
  2. is the same class of aircraft as the specified aircraft; and
  3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.]

[**Note**: A complete updated list of all Corporate Aircraft must be provided to **Us** on each anniversary of the **Policy**.]

Other Limitations and Exclusions that apply to this **Hazard** are in Section VIII Limitations and Section IX General Exclusions.
H4-XX]

SECTION V – ADDITIONAL COVERAGES

[**SPECIFIED PILOT COVERAGE**

The **Hazard** Exclusion in [**24 Hour Accident Protection**, **Business and Pleasure** [**Excluding**][**Including**] **Corporate Owned or Leased Aircraft**, [**and Substitute Aircraft**,] [**Passenger Only**] [**Passenger and Crew**]] [**24 Hour Accident Protection While on Business Trip**, [**Excluding**] [**Including**] **Corporate Owned or Leased Aircraft**, [**and Substitute Aircraft**,][**Passenger Only**] [**Passenger and Crew**]] [**24 Hour Accident Protection While [on a Specified Trip**] [**Attending a Specified Event**], [**Excluding**] [**Including**] **Corporate Owned or Leased Aircraft** [**and Substitute Aircraft**,] [**Passenger Only**] [**Passenger and Crew**]] [**Full Occupational Coverage**, [**Excluding**] [**Including**] **Corporate Owned or Leased Aircraft**, [**and Substitute Aircraft**,] [**Passenger Only**] [**Passenger and Crew**]] stating that **"Coverage** is not provided: **1.** if the [**Primary Insured Person**][**Insured Person**] is the pilot, operator, member of the crew or cabin attendant of any aircraft." is modified to provide **Coverage** for the following named pilot(s) only:

[**Pilot Name**(**s**)]

while piloting the following aircraft:

[**Aircraft Description**(**s**)]

provided such aircraft has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor, and the above named pilot(s) has a current and valid medical certificate and pilot certificate with a proper rating to fly such aircraft.

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

C1-XX]

[**BOMB SCARE/EXPLOSION COVERAGE**

Coverage is extended to include a **Covered Injury** caused by, or resulting from, a **Bomb Scare**, **Bomb Search**, **Bomb Explosion** [or **Fire Drill**] occurring on the premises of the **Policyholder**, subject to the following definitions:

- **Bomb** means any real or imitative explosive device placed with intent to cause injury, damage or scare.
- **Scare** means any real or false report of the presence of a **Bomb** on the premises of the **Policyholder**.
- **Search** means any organized search for a reported **Bomb**.
- **Explosion** means any explosion of a **Bomb** on the **Policyholder's** premises whether or not the presence of a **Bomb** was reported in advance.
- [**Fire Drill** means while participating in a **Fire Drill** conducted by the **Policyholder** for the purpose of emergency preparedness.]

[For purposes of on-premises **Bomb Scare/Explosion Coverage**, [as well as [[on-premises] Felonious Assault Coverage,][On-Premises Terrorism Coverage,][War Risk Coverage,]][the **Aggregate Limit of Liability** per **Covered Accident** [combined] is [$0.00].]

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

C2-XX]

[**COMMUTATION COVERAGE**

Coverage is extended to include a **Covered Injury** sustained by a **Primary Insured Person** while commuting directly to or from his or her home and place of regular employment. This **Coverage** begins when the **Primary Insured Person** leaves his or her home or place of work. This **Coverage** ends when the **Primary Insured Person** arrives at his or her home or place of work.

Except for events beyond the control of the **Primary Insured Person**, excluded **Injuries** are those arising out of or in the course of any deviation from the **Primary Insured Person's** normal route for personal reasons.

[This **Coverage** will not be extended if the **Primary Insured Person** is the operator of a private passenger automobile at the time he or she incurs such **Covered Injury** and i**s** either:

1. under the influence of alcohol;
   a. The **Primary Insured Person** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Primary Insured Person's** intoxication. Or,
2. under the influence of

   [a [poison,] [fume,] [noxious chemical substance]that was deliberately ingested][;][or][a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.]]

   [a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions.]]

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

C3-XX]

EXPOSURE AND DISAPPEARANCE COVERAGE

If [a **Primary Insured Person**] [an **Insured Person**] is exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which [a **Primary Insured Person**] [an **Insured Person**] is riding disappears, is wrecked, or sinks, and the [**Primary Insured Person**] [**Insured Person**] is not found within [365] days of the event, **We** will presume that the person lost his or her life as a result of **Injury**. If travel in such conveyance was covered under the terms of this **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that the [**Primary Insured Person**] [**Insured Person**] survived the event.

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

C4-XX

[EXTRA-ORDINARY COMMUTATION COVERAGE

Coverage is extended to include a **Covered Injury** sustained by a **Primary Insured Person** while commuting directly between his or her home, and place of regular employment. This can be by car or other conveyance. For this **Coverage** to take effect, there must be a stop in service due to a strike or major breakdown of one or more public transit systems regularly used by the **Primary Insured Person**.

This **Coverage** begins when the **Insured Person** leaves his or her home or place of work. This **Coverage** ends when the **Primary Insured Person** arrives at his or her home or place of work. Except for events beyond the control of the **Insured Person**, no losses will be covered if the **Primary Insured Person** deviates from his or her normal route.

[This **Coverage** will not be extended if the **Primary Insured Person** is the operator of a private passenger automobile at the time he or she incurs such **Covered Injury** and is either:

1. under the influence of alcohol;
   a. The **Primary Insured Person** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Primary Insured Person's** intoxication. Or,
2. under the influence of

   [a [poison,] [fume,] [noxious chemical substance] that was deliberately ingested][;][or][a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.]]

[a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions.]]

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

C5-XX]

[**FAMILY TRAVELING WITH EMPLOYEE ON BUSINESS AND/OR RELOCATION TRIPS COVERAGE**

The **Spouse**[/**Domestic Partner**] and/or a **Dependent Child** of a covered employee will also be considered a **Primary Insured Person** when he or she is traveling on a business and/or relocation trip with the covered employee that is approved by and at the expense of the **Policyholder**. The **Coverage** for the **Spouse**[/**Domestic Partner**] and/or a **Dependent Child** will be limited to the **Accidental Death Benefit** and the [**Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]** as stated in this **Policy**, when the eligibility for such **Benefit** results from the **Hazards** covered by this **Policy**.

This **Coverage** for the **Spouse** [/**Domestic Partner**] and/or **Dependent Child(ren)** ends upon arrival at the destination of the **Policyholder's** last reimbursed trip.

The **Principal Sum** for the **Spouse** [/**Domestic Partner**] and each **Dependent Child** will be as follows:

Spouse [/**Domestic Partner**]: $[50,000]
Dependent Child(ren): $[25,000]

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

C6-XX]

[**FELONIOUS ASSAULT COVERAGE**

Coverage is extended to a **Primary Insured Person** who sustains a **Covered Injury** as defined under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia]Benefit]**, as a direct result of a violent or criminal act committed by someone other than the **Primary Insured Person**, [a **Fellow Employee] [**or a member of his or her **Family** or **Household**,] provided:

1. [the **Injury** is incurred in connection with or related to the **Policyholder's** business; and]
2. the **Injury** occurs on the **Policyholder's** premises.

[For purposes of this **Coverage**:

[Fellow Employee means a person employed by the same employer as the **Primary Insured Person** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than [forty-five (45) days] prior to the date on which the defined violent crime/felonious assault was committed.]

[Family means the **Primary Insured Person's** parent, stepparent, **Spouse** or former **Spouse**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.]

[Household means a person who maintains residence at the same address as the **Primary Insured Person**.]

[This **Coverage** applies [only to the crimes or attempted crimes of robbery, theft, holdup, kidnapping.][to any willful or unlawful use of force in connection with the commission of or the attempt to commit a crime including, but not limited to, [robbery,][theft,][kidnapping,][hostage-taking,][assault,][battery,][sniping,][murder,][manslaughter,][riot,] or [insurrection]) that: 1.) results in a covered injury; and 2.) is a felony in the jurisdiction in which it occurs.]]

[For purposes of [on-premises] **Felonious Assault Coverage**, [as well as [on-premises Bomb Scare/Explosion Coverage,] [On-Premises Terrorism Coverage,][War Risk Coverage,]][the **Aggregate Limit of Liability** per **Covered Accident** [combined] is [$0.00].]]

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

C7-XX]

[**HIJACKING** or **SKYJACKING COVERAGE**

The exclusion for war or any acts of war whether declared or undeclared as found in Section IX General Exclusions of this **Policy** is modified, and **Covered Injuries** directly resulting from a **Hijacking** or **Skyjacking** or any attempt at any **Hijacking** or **Skyjacking** are covered under this **Policy**.

Hijacking or **Skyjacking** means the unlawful seizure or wrongful exercise of control of an aircraft [or conveyance] or the crew thereof, in which the [**Primary Insured Person**] [**Insured Person**] is traveling as a passenger.

This **Coverage** will continue beyond the actual **Hijacking** or **Skyjacking** while the [**Primary Insured Person**] [**Insured Person**] is:

1. subject to the control of the person(s) making the **Hijacking** or **Skyjacking**; and
2. traveling directly to the [**Primary Insured Person's**] [**Insured Person's**] home or original destination.

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

C8-XX]

[**ON-PREMISES TERRORISM COVERAGE**

Coverage is extended to a **Primary Insured Person** who sustains a **Covered Injury** as defined under the **Accidental Death Benefit [**or **Accidental Dismemberment** [**and Covered Loss of Use**][**and Plegia**] **Benefit]** as a direct result of an **Act of Terrorism** while the **Primary Insured Person** is performing the **Policyholder's** business on the **Policyholder's** premises.

[The benefit for this **On-Premises Terrorism Coverage** will be [15%] of the applicable **Principal Sum** subject to a maximum of [$100,000].]

Act of Terrorism means any intentionally violent or forceful act of any person(s), acting on behalf of an organization or group, with the purpose of creating political turmoil or overthrowing any government.

[We may cancel this **On-Premises Terrorism Coverage** by sending the **Policyholder**, at its most recent address in **Our** records, a [ten (10)] day notice of **Our** intent to cancel. Any unearned premium at the time of a cancellation will be promptly calculated and returned to the **Policyholder** on a pro-rata basis, but the return of the unearned premium is not a condition of cancellation. A change or termination in this **Coverage** will not affect a claim that begins while this **Coverage** is in force.]

[For purposes of **On-Premises Terrorism Coverage**, [as well as [[on-premises] Felonious Assault Coverage,] [on-premises Bomb Scare/Explosion Coverage,] [War Risk Coverage,]][the **Aggregate Limit of Liability** per **Covered Accident** [combined] is [$0.00].]]

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

C9-XX]

[**RESERVE CORPS/NATIONAL GUARD UNIT COVERAGE**

If a **Primary Insured Person** sustains an **Injury**, resulting in a **Covered Loss**, as defined under the **Accidental Death Benefit [**or **Accidental Dismemberment [**or **National and Covered Loss of Use][and Plegia] Benefit]**, while the **Primary Insured Person** is a member of an organized **Reserve Corps Guard Unit** and as such, the **Primary Insured Person** is:

1. attending any regularly scheduled or routine training of less than [sixty (60)] days, or the **Primary Insured Person** is enroute to or from such training;
2. attending a **Service School** or the **Primary Insured Person** is enroute to or from such **Service School**;
3. taking part in any authorized inactive duty training; or,
4. taking part as a unit member in a parade or exhibition authorized by official orders;

the **Primary Insured Person** will be eligible to receive the applicable **Principal Sum** for such **Covered Loss**.

[No benefit will be payable for any loss that occurs during active duty.]

For purposes of this **Coverage**, **Service School** means one operated by, or on behalf of, the United States of America or Canada.

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

C10-XX]

[**WAR RISK COVERAGE**

The exclusion for war or any acts of war, whether declared or undeclared, as found in Section IX General Exclusions of this **Policy** is modified, and **Covered Injuries** directly resulting from war or any acts of war, whether declared or undeclared, are covered under this **Policy** provided:

1. the war or act of war causing the **Injury** does not occur within any of the states of the United States of America (including the District of Columbia) [or Canada,] [named country or countries,] [or the [**Primary Insured Person's**] [**Insured Person's**] country of [residence] [citizenship]].[or

2. the war or act of war causing the **Injury** occurs in one of the following countries:

[named country or countries]

and the **Policyholder** reports actual exposure within these countries, to **Us**, as indicated below.]

[For those countries listed above in Paragraph [**1.** except for the United States of America, the District of Columbia, [Canada,] [and the [**Primary Insured Person's**] [**Insured Person's**] country of [residence] [citizenship]],] [**2.** loss that results from war or any act of war, whether declared or undeclared, will only be covered, if the **Policyholder** submits to **Us** [on an annual basis] a report of actual exposure within those areas. This report must include:

- the number of exposed **Primary Insured Persons**;
- the **Principal Sum** or Class of each **Primary Insured Person**;
- the country or countries visited by each **Primary Insured Person**;
- the dates visited, including the duration of the visit(s).

Additional premium due, if any, will be calculated at the standard war risk rates then in force.]]

[This **War Risk Coverage** [is][as well as [On-Premises Terrorism Coverage,] [[on-premises] Felonious Assault Coverage,] [on-premises Bomb Scare/Explosion Coverage,] [are] subject to an **Aggregate Limit of Liability** per **Covered Accident** [combined] of [$0.00].]

[We may, by giving [seven (7)] days written notice to the **Policyholder**, (1) require additional premium, to be calculated at the standard war risk rates utilized at the time of the exposure; (2) amend the list of countries above; or (3) cancel this **Coverage**. Any revision or cancellation will not prejudice any claim that occurred prior to the effective date of the revision or cancellation. Any unearned premium at the time of a cancellation will be promptly calculated and returned to the **Policyholder** on a pro-rata basis, but the return of the unearned premium is not a condition of cancellation. **Our** failure to exercise any of **Our** rights under this **Coverage** will not be deemed a waiver of these rights.]

Limitations and Exclusions that apply to this **Coverage** are in Section VIII Limitations and Section IX General Exclusions.

C11-XX]

SECTION VI – BENEFITS

ACCIDENTAL DEATH BENEFIT

We will pay the applicable **Principal Sum**, if [a **Primary Insured Person**] [an **Insured Person**] sustains a loss of life as a result of a **Covered Injury**, and the death occurs within [365] days of the **Covered Injury**.

This benefit is subject to the limitations in Section VIII Limitations.

B1-XX

[**ACCIDENTAL DISMEMBERMENT** [**AND COVERED LOSS OF USE**] [**AND PLEGIA**] **BENEFIT**

We will pay the benefit amount shown below, if an **Injury** to [a **Primary Insured Person**] [an **Insured Person**] [or a **Covered Spouse** [/**Domestic Partner**]] results in any of the following **Covered Losses**, provided the **Covered Loss** occurs within [365] days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person sustaining the **Covered Loss**.

Covered Loss of	**Benefit**

• Both Hands or Both Feet	[**Principal Sum**]
• One Hand and One Foot	[**Principal Sum**]
• One Hand or One Foot plus the loss of Sight of One Eye	[**Principal Sum**]
• Sight of Both Eyes	[**Principal Sum**]
• Speech and Hearing	[**Principal Sum**]
• Speech or Hearing	[50% of **Principal Sum**]
• One Hand; One Foot; or Sight of One Eye	[50% of **Principal Sum**]
• Thumb and Index Finger of the same Hand	[25% of **Principal Sum**]
• [Hearing in One Ear	[25% of **Principal Sum**]]

[A reduced benefit will be payable equal to [50%] of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after [365 days], the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.]

[**Covered Loss of Use** of	**Benefit**
• Four **Limbs**	[**Principal Sum**]
• Three **Limbs**	[75% of **Principal Sum**]
• Two **Limbs**	[66 2/3% of **Principal Sum**]
• One **Limb**	[50% of **Principal Sum**]]

[**Plegia**	**Benefit**
• Quadriplegia (total paralysis of all four **Limbs**)	[**Principal Sum**]
• [Triplegia (total paralysis of three **Limbs**)	[75% of **Principal Sum**]]
• Paraplegia (total paralysis of both lower **Limbs**)	[66 2/3% of **Principal Sum**]
• Hemiplegia (total paralysis of upper and lower **Limbs** on one side of the body)	[50% of **Principal Sum**]
• [Uniplegia (total paralysis of one **Limb**)	[25% of **Principal Sum**]]]

For purposes of this benefit:

- **Covered Loss** means:
  - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
  - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
  - **c.** Total and permanent loss of sight;
  - **d.** Total and permanent loss of speech;
  - **e.** Total and permanent loss of hearing.
- [**Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which [has continued for [12] consecutive months and] is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.]
- [**Plegia** must [continue for [twelve (12)] consecutive months and] be determined by **Our** competent medical authority to be a permanent, complete and irreversible paralysis of [two] or more **Limbs**. A **Limb** means an arm or a leg. Proof of total paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.]

This benefit is subject to the limitations in Section VIII Limitations.

[B2-XX][B3-XX][B4-XX]]

[ACCIDENTAL DISMEMBERMENT [AND COVERED LOSS OF USE] [AND PLEGIA] BENEFIT FOR COVERED DEPENDENT CHILDREN

We will pay the benefit shown, if an **Injury** to a **Covered Dependent Child(ren)** results in any of the following **Covered Losses**, provided the **Covered Loss** occurs within [365] days of the **Accident**:

Covered Loss of	**Percentage** of **Primary Insured Person's Principal Sum**

• Both Hands or Both Feet	[50%] to a maximum of $[100,000]
• One Hand and One Foot	[50%] to a maximum of $[100,000]
• One Hand or One Foot plus the loss of Sight of One Eye	[50%] to a maximum of $[100,000]
• Sight of Both Eyes	[50%] to a maximum of $[100,000]
• Speech and Hearing	[50%] to a maximum of $[100,000]
• Speech or Hearing	[25%] to a maximum of $[50,000]
• One Hand; One Foot; or Sight of One Eye	[25%] to a maximum of $[50,000]
• Thumb and Index Finger of the same Hand	[12.5%] to a maximum of $[25,000]
• [Hearing in One Ear	[12.5%] to a maximum of $[25,000]]

[A reduced benefit will be payable equal to [50%] of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after [365 days], the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.]

[**Covered Loss of Use** of	**Percentage** of **Primary Insured Person's Principal Sum**
• Four **Limbs**	[50%] to a maximum of $[100,000]
• Three **Limbs**	[37.5%] to a maximum of $[75,000]
• Two **Limbs**	[33%] to a maximum of $[66,000]
• One **Limb**	[25%] to a maximum of $[50,000]]

[**Plegia**	**Percentage** of **Primary Insured Person's Principal Sum**
• Quadriplegia (total paralysis of all four **Limbs**)	[50%] to a maximum of $[100,000]
• [Triplegia (total paralysis of three **Limbs**)	[37.5%] to a maximum of $[75,000]]
• Paraplegia (total paralysis of both lower **Limbs**)	[33%] to a maximum of $[66,000]
• Hemiplegia (total paralysis of upper and lower **Limbs** on one side of the body)	[25%] to a maximum of $[50, 000]
• [Uniplegia (total paralysis of one **Limb**)	[12.5%] to a maximum of $[25,000]]]

For purposes of this **Benefit**:

- **Covered Loss** means:
  - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
  - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
  - **c.** Total and permanent loss of sight;
  - **d.** Total and permanent loss of speech;
  - **e.** Total and permanent loss of hearing.
- [**Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which [has continued for [twelve (12)] consecutive months and] is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.]
- [**Plegia** must [continue for [twelve (12)] consecutive months and] be determined by **Our** competent medical authority to be permanent, complete and irreversible paralysis of [two (2)] or more **Limbs**. A **Limb** means an arm or a leg. Proof of total paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.]

This benefit is subject to the limitations in Section VIII Limitations.

[B5-XX][B6-XX][B7-XX]]

[ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT

We will pay the benefit **s**hown below, if an **Injury** to [a **Primary Insured Person**] [an **Insured Person**] results in any of the following **Covered Losses**, provided **t**he **Covered Loss** occurs within [365] days of the **Accident**.

The benefit amounts are based on the [**Primary Insured Person's**] [**Insured Person's**] **Principal Sum**.

Covered Loss of	**Benefit**
1. Two **Limbs**	[**Principal Sum**]
2. Both hands or all fingers and thumbs of both hands	[**Principal Sum**]
3. Sight of both eyes	[**Principal Sum**]
4. Paralysis of all **Limbs**	[**Principal Sum**]
5. One arm at shoulder	[60% of **Principal Sum**]
6. One arm between shoulder and elbow	[50% of **Principal Sum**]
7. One arm at elbow	[47.5% of **Principal Sum**]
8. One arm between elbow and wrist	[45% of **Principal Sum**]
9. One hand at wrist	[42.5% of **Principal Sum**]
10. Four fingers and thumb of one hand	[42.5% of **Principal Sum**]
11. Four fingers of one hand	[35% of **Principal Sum**]
12. Phalanges of one thumb	[20% of **Principal Sum**]
13. One phalanx of one thumb	[10% of **Principal Sum**]
14. Three phalanges of one index finger	[10% of **Principal Sum**]
15. Two phalanges of one index finger	[8% of **Principal Sum**]
16. One phalanx of one index finger	[4% of **Principal Sum**]
17. Three phalanges of one middle finger	[6% of **Principal Sum**]
18. Two phalanges of one middle finger	[4% of **Principal Sum**]
19. One phalanx of one middle finger	[2% of **Principal Sum**]
20. Three phalanges of one ring finger	[5% of **Principal Sum**]
21. Two phalanges of one ring finger	[4% of **Principal Sum**]
22. One phalanx of one ring finger	[2% of **Principal Sum**]
23. Three phalanges of one little finger	[4% of **Principal Sum**]
24. Two phalanges of one little finger	[3% of **Principal Sum**]
25. One phalanx of one little finger	[2% of **Principal Sum**]
26. First or second metacarpal	[3% of **Principal Sum** each]
27. Third fourth or fifth metacarpal	[2% of **Principal Sum** each]
28. One leg at hip	[50% of **Principal Sum**]
29. One leg between hip and knee	[50% of **Principal Sum**]
30. One leg below the knee	[40% of **Principal Sum**]
31. All toes of one foot	[15% of **Principal Sum**]
32. Both phalanges of one great toe	[5% of **Principal Sum**]
33. One phalanx of one great toe	[2% of **Principal Sum**]
34. Toes other than great toe	[1% of **Principal Sum** each]
35. One eye by removal	[30% of **Principal Sum**]
36. All sight in one eye	[25% of **Principal Sum**]
37. All sight in one eye except for perception of light	[25% of **Principal Sum**]
38. All the lens of one eye	[20% of **Principal Sum**]
39. All hearing in both ears	[40% of **Principal Sum**]
40. All hearing in one ear	[7% of **Principal Sum**]

[A reduced benefit will be payable equal to [50%] of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after [365] days, the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.]

For purposes of this benefit, **Covered Loss** means the actual severance of any member or the total and permanent **Loss of Use** of such member. **Covered Loss of Use** means total paralysis of the member, which is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.

[The benefit for:

1. any and all phalanges of the fingers and thumb of one hand in the aggregate will not exceed the benefit for the **Covered Loss** of four fingers of one hand; and
2. any or all of the phalanges of the fingers of one hand in the aggregate will not exceed the benefit for the **Covered Loss** of four fingers of one hand.]

This benefit is subject to the limitations in Section VIII Limitations.

B8-XX]

[**COMA BENEFIT**

We will pay a **Coma Benefit**, if [**You** sustain] [an **Insured Person** sustains] an **Injury** within [365] days of an **Accident**, and such **Injury** causes the [**Primary Insured Person**] [**Insured Person**] to be in a **Coma** for at least [thirty-one (31)] consecutive days.

[The **Coma Benefit** is equal to [1%] of the [**Primary Insured Person's**] [**Insured Person's**] **Principal Sum**, and will be paid each month the [**Primary Insured Person**] [**Insured Person**] remains in a **Coma** following the initial [thirty-one (31)] day period. The **Coma Benefit** will end on the earliest of the following:

1. the [**Primary Insured Person**] [**Insured Person**] is no longer in a **Coma** which directly resulted from the **Injury**;
2. the [**Primary Insured Person**] [**Insured Person**] has received a **Coma Benefit** for [100] months.]

[The **Coma Benefit** will be payable at [1%] of the [**Primary Insured Person's**] [**Insured Person's**] **Principal Sum** per month for the first [11] months the [**Primary Insured Person**] [**Insured Person**] remains in a **Coma**, following the initial [thirty-one (31)] day period. At the end of the [11] months of payment, if the [**Primary Insured Person**] [**Insured Person**] remains in a **Coma**, **We** will pay a lump sum benefit equal to the **Principal Sum** payable under the **Accidental Death Benefit** less the amount of the [11] months of benefit already received.]

Brief periods of consciousness of no more than [one (1) day] in duration will not effect the [**Primary Insured Person's**] [**Insured Person's**] eligibility for, or continuation of, benefits.

Coma will be determined by **Our** duly licensed **Physician**.

This benefit is subject to the limitations in Section VIII Limitations.

B9-XX]

[**HIV OCCUPATIONAL ACCIDENT BENEFIT**

We will pay an **HIV Benefit**, if a **Primary Insured Person** sustains an **Injury** resulting in a **Covered Loss** while performing his or her job related duties, which causes him or her to acquire and test positive within [365 days] of such **Accident** for Human Immunodeficiency Virus (HIV) and/or AIDS and related complex (ARC). Such **HIV Benefit** will be equal to [20%] of the **Primary Insured Person's Principal Sum** at the date of the **Accident**, but will not exceed [$50,000]. The **HIV Benefit** will be paid in [twenty-four (24)] equal monthly installments.

In order to receive the **HIV Benefit**, the **Primary Insured Person** must:

1. submit a Workers' Compensation injury report to his or her employer within forty-eight (48) hours of the **Accident**. If the **Primary Insured Person's** employer does not maintain Workers' Compensation insurance, the **Primary Insured Person** must complete an **Accident** report on a form that **We** will provide. The completed **Accident** report must be approved by the **Policyholder** within forty-eight (48) hours of the **Accident** and must be submitted to **Us** within five (5) days of the **Accident**; and
2. submit to a blood test for HIV and/or AIDS and/or related complex (ARC) within forty-eight (48) hours of the **Accident**, which is administered by a duly licensed medical doctor or registered nurse. The blood test results must be sent directly to **Us**.

If the initial test is negative, and the **Primary Insured Person** subsequently tests positive for HIV, AIDS or ARC within [365 days] of the **Accident**, **We** will begin monthly payments on the first of the month following the settlement of the claim.

This benefit is subject to the limitations in Section VIII Limitations.

B10-XX]

[**IN-HOSPITAL INDEMNITY BENEFIT**

We will pay:

1. a monthly benefit of [1%] of the [**Primary Insured Person's**] [**Insured Person's**] **Principal Sum** to a maximum of [$1,000]; or

2. for periods of less than one (1) month, one thirtieth of the amount calculated in number 1 above, for each complete day of confinement,

if [a **Primary Insured Person**] [an **Insured Person**] sustains an **Injury** resulting in a **Covered Loss** that requires him or her to be confined in a **Hospital** for more than [seven (7)] consecutive days.

The initial **Hospital** confinement must begin within [ninety (90)] days of the **Injury** for the **[Primary Insured Person**] [**Insured Person**] to be eligible for this benefit.

This benefit will be paid for a maximum of [twelve (12)] months for any **Covered Injury**.

Successive periods of **Hospital** confinement arising out of the same **Injury** will be considered one confinement only if they are separated by a period of less than three (3) months.

The term **Hospital** means a health care facility that meets all of the following requirements:

1. holds a license as a hospital, if required;

2. operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;

3. provides twenty-four (24) hour a day nursing service by registered nurses;

4. has a staff of one or more licensed **Physicians** available at all times;

5. has facilities for diagnosis, and major medical surgical facilities; and

6. is not primarily a clinic, nursing, rest or convalescent home or similar establishment, nor is not, other than incidentally, a substance abuse center or halfway house.

This benefit is subject to the limitations in Section VIII Limitations.

B11-XX]

[**PERMANENT AND TOTAL DISABILITY BENEFIT**

We will pay a **Permanent and Total Disability Benefit**, if a **Primary Insured Person** becomes **Permanently and Totally Disabled** as a result of a **Covered Injury**, provided that he or she becomes **Permanently and Totally Disabled** within [365] days of the **Injury**; and the **Permanent and Total Disability** continues for [twelve (12)] months. The benefit payable equals the **Primary Insured Person's Principal Sum** less any amount payable pursuant to the limitations in Section VIII Limitations of this **Policy**.

For purposes of this benefit, **Permanently and Totally Disabled** means that the **Primary Insured Person** is totally and continually disabled and cannot work, for any income, at any job that he or she is reasonably suited by education, training or experience to do. **Permanent and Total Disability** must be verified by a competent medical authority, and must be expected to continue for the remainder of the **Primary Insured Person's** life.

[Eligibility for this benefit ends at age [seventy (70)].]

B12-XX]

[PERMANENT AND TOTAL DISABILITY BENEFIT

We will pay a **Permanent and Total Disability Benefit**, if a **Primary Insured Person** becomes **Permanently and Totally Disabled** as a result of a **Covered Injury**, provided that he or she becomes **Permanently and Totally Disabled** within [365] days of the **Injury**; and the **Permanent and Total Disability** continues for [twelve (12)] months.

The monthly amount payable under this benefit will be equal to [1%] of the **Primary Insured Person's Principal Sum**. These payments will cease at the earlier of the time that:

1. **We** make [100] payments under this provision;
2. the **Primary Insured Person** is no longer **Permanently and Totally Disabled**;
3. the **Primary Insured Person** dies.

For purposes of this benefit, **Permanently and Totally Disabled** means that the **Primary Insured Person** is totally and continually disabled and cannot work, for any income, at any job that he or she is reasonably suited by education, training or experience to do. **Permanent and Total Disability** must be verified by a competent medical authority, and must be expected to continue for the remainder of the **Primary Insured Person's** life.

This benefit is subject to the limitations in Section VIII Limitations.

[Eligibility for this benefit ends at age [seventy (70)].]

B13-XX]

SECTION VII – ADDITIONAL BENEFITS

[**ACCIDENT DENTAL EXPENSE BENEFIT**

We will pay an **Accident Dental Expense Benefit**, if [a **Primary Insured Person**] [an **Insured Person**] sustains a **Covered Injury** which causes him or her to require treatment for damage to **Sound Natural Teeth**. This benefit will not exceed the **Reasonable and Customary** expenses incurred for the **Medically Necessary** treatment, replacement, or diagnosis of such **Sound Natural Teeth**, provided:

1. the damage to the teeth occurs within [thirty (30)] days of the **Covered Injury**;
2. the expenses are actually incurred and paid within [twenty-six (26)] weeks of the **Covered Injury**; and
3. the services are performed by a licensed dentist or dental surgeon.

The maximum amount payable under this benefit is $[3,000] for any one **Covered Accident**.

We will not cover expenses under this additional benefit for:

1. any expenses covered by Workers' Compensation;
2. any expenses covered by Medicare;
3. any services of a Federal, Veteran's, State or Municipal hospital for which [a **Primary Insured Person**] [an **Insured Person**] is not liable for payment;
4. expenses which are more than **Reasonable and Customary**;
5. cosmetic, plastic, or restorative dental treatment unless **Medically Necessary** for the treatment of the **Covered Injury**;
6. the replacement or repair of existing dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, or caps;
7. expenses which the [**Primary Insured Person**] [**Insured Person**] recovers in a settlement or court judgment;
8. expenses which are covered under any other insurance of any kind;
9. expenses which the [**Primary Insured Person**] [**Insured Person**] is not legally obligated to pay; or
10. expenses that are not **Medically Necessary** for the treatment of the **Covered Injury**.

Medically Necessary means that the dental service or treatment:

1. is essential for the diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed; and
2. meets generally accepted standards of dental practice.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;

2. the degree of professional skill required; and

3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

AB1-XX]

[**ACCIDENT MEDICAL EXPENSE BENEFIT**

We will pay an **Accident Medical Expense Benefit**, if [a **Primary Insured Person**] [an **Insured Person**] sustains a **Covered Injury**, which causes him or her to incur medical expenses. This benefit will not exceed the **Reasonable and Customary** expenses incurred by the [**Primary Insured Person**][**Insured Person**], in excess of the deductible of [$1,000.00] [and any other valid and collectible insurance], provided that:

1. the first treatment or service occurs within [thirty (30)] days of the **Covered Injury**;

2. the medical expenses are incurred within [365 days] of the **Covered Injury**; and

3. the [**Primary Insured Person**] [**Insured Person**] is under the care and treatment of a **Physician** other than his or her spouse, children or any other person who is related to him or her.

The maximum amount payable under this benefit is $[5,000] for any one **Covered Accident**.

We will not cover expenses under this additional benefit for:

1. any **Pre-existing Condition**, until the [**Primary Insured Person**] [**Insured Person**] has been continuously covered under this **Policy** for [twelve (12)] consecutive months;

2. any expenses which are covered by Workers' Compensation;

3. any expenses covered by Medicare;

4. any services of a Federal, Veteran's, State or Municipal hospital for which [a **Primary Insured Person**] [an **Insured Person**] is not liable for payment;

5. expenses which are more than the **Reasonable and Customary**;

6. cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Covered Injury**;

7. expenses which the [**Primary Insured Person**] [**Insured Person**] recovers in a settlement or court judgment;

8. expenses which are covered under any other insurance of any kind;

9. expenses which the[**Primary Insured Person**] [**Insured Person**] is not legally obligated to pay;

10. **Custodial Services**;

11. expenses that are not **Medically Necessary** for the treatment of the **Covered Injury**.

Custodial Services means any services that are not intended primarily to treat a specific **Injury**. **Custodial Services** include, but will not be limited to, services:

1. related to watching or protecting the [**Primary Insured Person**] [**Insured Person**];

2. related to performing or assisting the [**Primary Insured Person**] [**Insured Person**] in performing any activities of daily living such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered; and

3. that are not required to be performed by trained or skilled medical personnel.

Medically Necessary means that the medical service or treatment:

1. is essential for the diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed;

2. meets generally accepted standards of medical practice; and

3. is ordered by a **Physician** within the scope of his or her practice.

Pre-existing Condition means a condition for which the [**Primary Insured Person**] [**Insured Person**] has sought or received medical advice or treatment during the [twelve (12)] months immediately preceding his or her effective date of **Coverage** under this **Policy**.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;

2. the degree of professional skill required; and

3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

AB2-XX]

[**ACCIDENT WEEKLY INDEMNITY BENEFIT**

We will pay an **Accident Weekly Indemnity Benefit**, if a **Primary Insured Person** sustains a **Covered Injury**, which renders him or her **Totally Disabled**, provided:

1. the **Total Disability** occurs within [thirty (30)] days of the date of the **Injury**;

2. the **Primary Insured Person** has satisfied the **Benefit Waiting Period** of [seven (7)] days; and

3. the **Primary Insured Person** is being attended to by a duly licensed **Physician**, other than a family member.

Payments will begin on the first day after the benefit **Waiting Period** and will continue for as long as the **Primary Insured Person** is **Totally Disabled**, but will not exceed the **Benefit Period** of [fifty-two (52)] weeks. The amount of the payments will be equal to [75%] of the **Primary Insured Person's Base Weekly Earnings** [reduced by] [(1) Workers' Compensation Disability Benefit;] [(2) Social Security Disability Benefits excluding any amounts for which the **Primary Insured Person's Dependents** may qualify because of the **Primary Insured Person's** disability;] [(3) Social Security Retirement Benefits;] [(4) Group Disability Benefits sponsored by the **Policyholder**;] [(5) the amount of any disability income benefits from any automobile or no-fault policy or insurance].

This **Accident Weekly Indemnity Benefit** will not exceed the **Weekly Indemnity Amount** of [$400.00].

Additional Definitions:

- **Base Weekly Earnings** is **Base Annual Earnings** divided by 52.
- **Benefit Period** means the time period, after the end of the benefit **Waiting Period**, that benefits are payable under this benefit subject to any other restrictions or limitations in the **Policy**.
- **Total Disability** (**Totally Disabled**) means that the **Primary Insured Person** is unable to perform all the substantial and material duties required by his or her regular occupation.
- **Benefit Waiting Period** means the number of consecutive days at the start of a period of continuous **Total Disability** for which **We** will not pay benefits.

AB3-XX]

[**ADDITIONAL DISMEMBERMENT BENEFIT FOR CHILDREN**

We will pay the **Primary Insured Person** a benefit that will be equal to an additional [100%] of the benefit amount provided by the **Accidental Dismemberment Benefit** that is payable under the **Accidental Dismemberment Benefit**, if the **Primary Insured Person** selects a **Plan** covering his or her eligible **Dependent Child(ren)**, and a **Covered Dependent Child** sustains an **Injury** resulting in a **Covered Loss**.

AB4-XX]

[**AFTER SCHOOL CARE BENEFIT**

We will pay an additional benefit for After School Care, if a **Primary Insured Person** [selects a **Plan** covering his or her **Dependents** and the **Primary Insured Person [**or his or her **Covered Spouse** [/**Domestic Partner**]]] sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to the individual who incurs the expense on behalf of each [**Covered**] **Dependent Child** if:

1. on the date of the **Accident**, the [**Covered**] **Dependent Child** was enrolled in After School Care, or enrolls in such After School Care within [ninety (90)] days from the date of **Covered Loss**; and

2. the [**Covered**] **Dependent Child** is under age [13].

The **After School Care Benefit** will be equal to the lesser of:

1. the actual cost of the After School Care;

2. [2%] of the **Principal Sum** of the [**Primary Insured Person**] [**Insured Person**] who sustained the **Covered Loss**; or

3. [$2,000].

[If both the **Primary Insured Person** and his or her **Covered Spouse** [/**Domestic Partner**] sustain a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **After School Care Benefit** will be based on the **Primary Insured Person's Principal Sum**.]

The **After School Care Benefit** will be paid annually for up to [four (4)] consecutive years, if:

1. the [**Covered**] **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and

2. proof, acceptable to **Us**, is received by **Us** that verifies that the [**Covered**] **Dependent Child** remains enrolled in After School Care.

The After School Care provider may not be a relative or family member and proof, acceptable to **Us** must be provided to establish eligibility for this benefit.

[The maximum amount payable for all eligible [**Covered**] **Dependent Children** under this benefit is [$8,000].]

AB5-XX]

[**CARJACKING BENEFIT**

We will pay an additional benefit equal to [10%] of the applicable **Principal Sum** to a maximum of [$10,000], if [a **Primary Insured Person**] [an **Insured Person**] sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, as a direct result of an **Accident** that occurs during a **Carjacking** of a private passenger automobile that the [**Primary Insured Person**] [**Insured Person**] was operating, getting into or out of, or riding in as a passenger.

Verification of the **Carjacking** must be made part of an official police report within [twenty-four (24)] hours of the **Carjacking** or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within [twenty-four (24)] hours or as soon as reasonably possible, and such verification must be provided to **Us**.

For purposes of this benefit, **Carjacking** means a person other than the [**Primary Insured Person**] [**Insured Person**] taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

AB6-XX]

[**COBRA BENEFIT**

We will pay an additional benefit to continue medical insurance for the **Primary Insured Person's** surviving family members for a period of [one (1) year] from the date of the **Covered Loss**, if a **Primary Insured Person** [selects a **Plan** covering his or her **Dependents** and the **Primary Insured Person**] sustains an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, and the **Primary Insured Person** is covered under a medical plan sponsored by the **Policyholder**. The amount payable under this benefit will be the lesser of:

1. [5%] of the **Primary Insured Person's Principal Sum**;

2. [$5,000]; or

3. The actual cost to the surviving family members to continue medical coverage for [one (1) year] under the plan sponsored by the **Policyholder**.

AB7-XX]

[**COMMON CARRIER BENEFIT**

We will pay an additional benefit equal to the lesser of [$50,000] or [50%] of the [**Primary Insured Person's**] [**Insured Person's**] **Principal Sum**, if [a **Primary Insured Person**] [an **Insured Person**] sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of**

Use][and Plegia] Benefit], provided the [**Primary Insured Person**][**Insured Person**] sustains the **Injury** while a passenger riding in or on, boarding, or getting off a **Common Carrier**.

For purposes of this benefit, **Common Carrier** means:

1. any land or water conveyance licensed to carry persons for hire;

2. any civilian aircraft that holds a certificate of Public Convenience and Necessity, a license, or a similar permit for civilian scheduled air carriers issued by the country where the aircraft is registered.

AB8-XX]

[**COMMON DISASTER BENEFIT**

If a **Primary Insured Person** selects a **Plan** covering his or her **Dependents** and the **Primary Insured Person** and his or her **Covered Spouse** [**/Domestic Partner**] are both eligible for **Accidental Death Benefits** as a result of **Covered Injuries** sustained in the same **Accident** [and within [ninety (90)] days of such **Accident**,] the **Principal Sum** that would have been payable because of the **Covered Spouse's**[**/Domestic Partner's**] **Accidental Death Benefit** will be increased to equal that payable for the loss of the **Primary Insured Person**, provided [:

1. the **Primary Insured Person** and **Covered Spouse**[**/Domestic Partner**] are survived by one or more **Covered Dependent Child(ren)**; and

2.]the combined benefits of the **Primary Insured Person** and the **Covered Spouse** [**/Domestic Partner**] are not more than [$500,000].

AB9-XX]

[**CONTINUATION OF COVERAGE BENEFIT**

All **Coverages** under this **Policy** that were in force on the date of the indicated **Covered Loss**, with respect to **Insured Persons** other than the **Primary Insured Person**, will be continued automatically for [365 days] after the date of the **Covered Loss** at no additional cost, if the **Primary Insured Person** selects a **Plan** covering his or her **Dependents**, and the **Primary Insured Person** sustains an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**.

AB10-XX]

[**CRITICAL BURN BENEFIT**

An additional benefit will be payable equal to the lesser of [10%] of the applicable **Principal Sum** or [$10,000], if [a **Primary Insured Person**] [an **Insured Person**] is critically burned as a result of a **Covered Accident**, provided all terms and conditions of the **Policy** are met and:

1. the [**Primary Insured Person**][**Insured Person**] has received [third] degree or higher burns over [25%] of his or her body; and

2. the [**Primary Insured Person**][**Insured Person**] has undergone reconstructive surgery to treat the burned areas of the body; and

3. the reconstructive surgery has taken place within [365 days] of the occurrence of the **Injury**.

This benefit will not be paid for a critical burn that results from voluntary self-exposure to the sun or to artificial tanning devices.

[If benefits are also payable under the **Reconstructive Surgery Benefit**, only one benefit will be paid, the largest benefit.]

AB11-XX]

[**DAY CARE BENEFIT**

We will pay an additional benefit for Day Care expenses, if a **Primary Insured Person** [selects a **Plan** covering his or her **Dependents** and the **Primary Insured Person [**or his or her **Covered Spouse** [**/Domestic Partner**]]] sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to the individual who incurs the expense on behalf of each [**Covered**] **Dependent Child** if:

1. on the date of the **Accident**, the [**Covered**] **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of **Covered Loss**; and

2. the [**Covered**] **Dependent Child** is under age [13].

The **Day Care Benefit** will be equal to the lesser of:

1. the actual cost of the Day Care;

2. [3%] of the **Principal Sum** of the [**Primary Insured Person**] [**Insured Person**] who sustained the **Covered Loss**; or

3. [$3,000].

[If both the **Primary Insured Person** and his or her **Covered Spouse** [**/Domestic Partner**] sustains a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **Day Care Benefit** will be based on the **Primary Insured Person's Principal Sum**.]

The **Day Care Benefit** will be paid annually for up to [four (4)] consecutive years, if:

1. the [**Covered**] **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and

2. proof, acceptable to **Us**, is received by **Us** that verifies that the [**Covered**] **Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

An **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;

2. is licensed by the state for such child care facilities; and

3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

[The maximum amount payable for all eligible [**Covered] Dependent Children** under this benefit is [$12,000].]

AB12-XX]

[**FELONIOUS ASSAULT BENEFIT**

We will pay an additional benefit equal to the lesser of [10%] of the **Primary Insured Person's Principal Sum** or [$30,000], if a **Primary Insured Person** sustains an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]** as a result of a violent or criminal act committed by someone other than the **Primary Insured Person**, [a **Fellow Employee**,**] [**or a member of his or her **Family** or **Household**,] provided:

1. the **Injury** is incurred in connection with the **Policyholder's** normal business whether on or off the **Policyholder's** premises[; and

2. the crime directly involves the **Policyholder's** funds or assets].

For purposes of this benefit:

[Fellow Employee means a person employed by the same employer as the **Primary Insured Person** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than [forty-five (45) days] prior to the date on which the defined violent crime/felonious assault was committed.]

[Family means the **Primary Insured Person's** parent, stepparent, **Spouse** or former **Spouse**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.]

[Household means a person who maintains residence at the same address as the **Primary Insured Person**.]

[This benefit applies [only to the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.][to any willful or unlawful use of force in connection with the commission of or the attempt to commit a crime including, but not limited to, [robbery,][theft,][kidnapping,][hostage-taking,][assault,][battery,][sniping,][murder,][manslaughter,][riot,] or [insurrection]) that: 1.) results in a covered injury; and 2.) is a felony in the jurisdiction in which it occurs.]]

AB13-XX]

[FUNERAL EXPENSE BENEFIT

We will pay an additional benefit for **Funeral Expenses** incurred within [thirty (30)] days of the **Covered Loss**, if [a **Primary Insured Person**] [an **Insured Person]** sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**.

The benefit amount will be equal to the lesser of [5%] of the [**Primary Insured Person's**] **[Insured Person's**] **Principal Sum** or [$5,000].

AB14-XX]

[**HEARING AID OR PROSTHETIC APPLIANCE BENEFIT**

We will pay an additional benefit, if [a **Primary Insured Person**] [an **Insured Person]** sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit**, provided:

1. the [**Primary Insured Person**] **[Insured Person**] is required to use a hearing aid or prosthetic appliance;
2. the **Injury** that caused the payment of the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit** is the same **Injury** that requires the [**Primary Insured Person**] **[Insured Person**] to use the **Hearing Aid or Prosthetic Appliance**; and
3. the **Hearing Aid or Prosthetic Appliance** is required within [365 days] of the **Injury**.

The amount **We** will pay will be equal to the one time cost of the **Hearing Aid or Prosthetic Appliance** actually paid by the [**Primary Insured Person**] **[Insured Person**].

This benefit will not be paid unless:

1. the **Hearing Aid or Prosthetic Appliance** was prescribed by a legally qualified **Physician** or surgeon who is not the [**Primary Insured Person's**] **[Insured Person's**] spouse, child, or relative; and
2. presentation of proof of payment is provided to **Us**.

For purposes of this benefit, **Prosthetic Appliance** will include an artificial limb or eye.

No payment will be made for ordinary living, traveling or clothing expenses.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [10%] of the [**Primary Insured Person's**] **[Insured Person's**] **Principal Sum** or [$10,000].

AB15-XX]

[**HIGHER EDUCATION BENEFIT**

We will pay an additional benefit for Higher Education expenses, if a **Primary Insured Person**[selects a **Plan** covering his or her **Dependents** and the **Primary Insured Person** [or his or her **Covered Spouse**[/**Domestic Partner**]]] sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to the individual who incurs the expense on behalf of each [**Covered**] **Dependent Child** if:

1. on the date of the **Accident**, the [**Covered**] **Dependent Child** was enrolled as a full-time student in an accredited college, university or trade school; or
2. the [**Covered**] **Dependent Child** was at the 12th grade level and enrolls in an accredited college, university or trade school within [one (1)] year from the date of the **Accident**.

The **Higher Education Benefit** will be equal to the lesser of:

1. [5%] of the **Principal Sum** of the [**Primary Insured Person**] [**Insured Person**] who sustained the **Covered Loss**; or
2. [$5,000].

[If both the **Primary Insured Person** and his or her **Covered Spouse** [/**Domestic Partner**] sustain a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **Higher Education Benefit** will be based on the **Primary Insured Person's Principal Sum**.]

The **Higher Education Benefit** will be paid annually for up to [four (4)] consecutive years, if:

1. the [**Covered**] **Dependent Child** continues his or her Higher Education ; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the [**Covered**] **Dependent Child** remains enrolled in an institution of higher learning on a full-time basis.

[The maximum amount payable for all eligible [**Covered] Dependent Children** under this benefit is [$20,000].]

[If, at the time of the **Accident**, a **Plan** covering the **Primary Insured Person's Dependents** was selected, but there are no [**Covered] Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of [$1,000] to the designated beneficiary.]

AB16-XX]

[**HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT**

We will pay an additional benefit for Home Alterations and/or Vehicle Modifications, if [a **Primary Insured Person**] [an **Insured Person**] sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit**, provided:

1. the [**Primary Insured Person**] [**Insured Person**] is required to use a wheelchair to be ambulatory on a permanent basis;
2. the **Injury** that caused the payment of the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit** is the same **Injury** that requires the [**Primary Insured Person**] [**Insured Person**] to need the wheelchair; and
3. the cost is incurred within [365 days] of the **Covered Loss**.

The amount **We** will pay will be equal to:

1. the one time cost of alterations to the [**Primary Insured Person's**] [**Insured Person's**] primary residence to make it wheelchair accessible and habitable; and
2. the one time cost of modifications necessary to his or her motor vehicle to make the vehicle accessible or drivable.

Benefits will not be payable unless:

1. alterations and/or modifications are made by a person or persons experienced in such alterations and/or modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. presentation of proof of payment is provided to **Us**.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [10%] of the [**Primary Insured Person's**] [**Insured Person's**] **Principal Sum** or [$10,000].

AB17-XX]

[**NATURAL DISASTER BENEFIT**

We will pay an additional benefit equal to the lesser of [10%] of the [**Primary Insured Person's**] [**Insured Person's**] **Principal Sum** or [$10,000], if [a **Primary Insured Person**] [an **Insured Person**] sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]** as a direct result of a **Natural Disaster**.

For purposes of this benefit, **Natural Disaster** means a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or other similar event.

AB18-XX]

[**PARENT CARE BENEFIT**

We will pay an additional benefit for **Parent Care**, if a **Primary Insured Person**[or his or her **Covered Spouse**[/**Domestic Partner**]] sustains an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**. This benefit will be paid in equal shares to each **Dependent Parent** (or his or her legal guardian) of such **Primary Insured Person** [and his or her **Covered Spouse** [/**Domestic Partner**].

The amount payable for the **Parent Care Benefit** will be [[$5,000.00] per **Dependent Parent**] [[5%] of the **Primary Insured Person's** [**Covered Spouse's**[/**Domestic Partner's**]] **Principal Sum]** to a maximum of [$40,000.00] for all **Dependent Parents**. Application for this benefit must be made within [ninety (90)] days of the **Covered Loss**.

For purposes of this benefit, **Dependent Parent** means the parent(s) or grandparent(s) of the **Primary Insured Person**[, or his or her **Covered Spouse[/Domestic Partner**]] who, at the time of a **Covered Accident**, is receiving support and care

provided by such **Primary Insured Person**[or **Covered Spouse**[/**Domestic Partner**]] as evidenced by the most current tax return filed with the government of the United States of America.

AB19-XX]

[RECONSTRUCTIVE SURGERY BENEFIT

We will pay an additional benefit for **Reconstructive Surgery**, if [a **Primary Insured Person][**an **Insured Person]** sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit**, provided:

1. the **Reconstructive Surgery** is determined to be medically necessary by a **Physician**; and

2. the **Reconstructive Surgery** has taken place within [365 days] of the occurrence of the **Injury**.

The benefit amount will be in excess of any amounts paid or payable by any other plans and will not exceed the lesser of [5%] of the [**Primary Insured Person's][Insured Person's] Principal Sum** or [$5,000].

[If benefits are also payable under the **Critical Burn Benefit**, only one benefit will be paid, the largest benefit.]

AB20-XX]

[**REHABILITATION BENEFIT**

We will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training**, if the **Primary Insured Person** sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit**. The benefit will be in an amount equal to the lesser of:

1. the actual expenses that are incurred within [two (2)] years from the date of the **Accident** for the **Rehabilitation Training**;

2. [$10,000]; or

3. [10%] of the **Primary Insured Person's Principal Sum**.

Rehabilitation Training means a treatment program that:

1. is prescribed by a licensed **Physician** acting within the scope of his or her license that is approved by **Us** prior to the provision of services;

2. is required due to the **Primary Insured Person's Injury**; and

3. prepares the **Primary Insured Person** for an occupation that he or she would not have engaged in except for the **Injury**.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;

2. the degree of professional skill required; and

3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

AB21-XX]

[**SEAT BELT**[**/AIR BAG**] **BENEFIT**

We will pay an additional benefit [equal to [10%] of the applicable **Principal Sum** up to a maximum] of [$10,000], if [a **Primary Insured Person**] [an **Insured Person]** sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, provided that the [**Primary Insured Person**] [**Insured Person**] was:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and

2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

Verification of the [**Primary Insured Person's**] [**Insured Person's**] actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Accident**, through certification by the investigating officers; or

2. by other reasonable proof, acceptable to **Us**.

[An additional benefit [equal to [5%] of the [**Primary Insured Person's**] [**Insured Person's**] **Principal Sum** to a maximum] of [$5,000], will be paid if the [**Primary Insured Person**] [**Insured Person**] was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile

with a manufacturer equipped passenger-side air bag, provided the [**Primary Insured Person's**] [**Insured Person's**] seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.]

[**We** will not pay a **Seat Belt** [or **Air Bag**] **Benefit** if the [**Primary Insured Person][Insured Person]** is the operator of a private passenger automobile at the time [**You** incur] [he or she incurs] such **Covered Injury** and is either:

1. under the influence of alcohol;

- **a.** [A **Primary Insured Person**] [An **Insured Person**] will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
- **b.** An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the [**Primary Insured Person's**] [**Insured Person's**] intoxication. Or,

2. under the influence of

[a [poison,] [fume,] [noxious chemical substance] that was deliberately ingested][;][or][a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.]]

[a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions.]]

AB22-XX]

[SPOUSE[/DOMESTIC PARTNER] VOCATIONAL TRAINING BENEFIT

We will pay the actual cost of any professional or trade-training program in which the **Primary Insured Person's** [**Covered**] **Spouse** [**/Domestic Partner**] enrolls, if the **Primary Insured Person** [selects a **Plan** covering his or her **Spouse** [**/Domestic Partner**], and the **Primary Insured Person**] sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to his or her [**Covered**] **Spouse** [**/Domestic Partner**], provided:

1. the purpose of the training program is to obtain an independent source of support and maintenance;

2. the actual cost is incurred within [thirty (30)] months from the death of the **Primary Insured Person**; [and

3. the professional or trade training program is licensed by the state.]

The maximum amount payable under this benefit will be [the lesser of [2%] of the **Primary Insured Person's Principal Sum** or] [$3,000].

AB23-XX]

[SURVIVOR BENEFIT

We will pay an additional benefit, if a **Primary Insured Person** [selects a **Plan** covering his or her **Dependents** and the **Primary Insured Person**,] sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. The benefit will be paid to the **Primary Insured Person's** [**Covered**] **Spouse** [**/Domestic Partner**]. [If there is no eligible [**Covered**]**Spouse**[/**Domestic Partner**], the benefit will be paid in equal shares to the [**Covered**]**Dependent Child(ren)** or their legal guardian.]

The [monthly] benefit will be equal to [1%] of the **Primary Insured Person's Principal Sum** [and will be paid for a period of [six (6) months] from the date of the **Covered Loss**] .

AB24-XX]

[**THERAPEUTIC COUNSELING BENEFIT**

We will reimburse the expenses for **Therapeutic Counseling**, if a **Primary Insured Person** [selects a **Plan** covering his or her **Dependents** and the **Primary Insured Person** or his or her **Covered Dependents**] sustains an **Injury** resulting in a **Covered Loss** that is payable under the [**Accidental Death Benefit] [**or] [**Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, and the **Primary Insured Person** [or his or her **Covered Dependents**] requires **Therapeutic Counseling**. The benefit will be paid to the individual who incurs the expense, provided:

1. all terms and conditions of the **Policy** are met;
2. **Therapeutic Counseling** begins within [ninety (90)] days of the **Covered Accident**;
3. **Therapeutic Counseling** expenses are incurred within [one (1) year] from the date of the **Covered Loss**.

Therapeutic Counseling means treatment or counseling provided by a licensed therapist or counselor who is registered or certified to provide psychological treatment or counseling.

The maximum amount payable under this benefit is $[1,000.00] for any one **Covered Accident**.

AB25-XX]

[**TERRORISM BENEFIT**

We will pay an additional benefit equal to the lesser of [10%] of the [**Primary Insured Person's][Insured Person's] Principal Sum** or [$30,000], if [the **Primary Insured Person**] [the **Insured Person**] sustains an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, that was directly caused by an **Act of Terrorism**.

Act of Terrorism means any intentionally violent or forceful act of any person(s), acting on behalf of an organization or group, with the purpose of creating political turmoil or overthrowing any government.

[We may cancel this **Terrorism Benefit** by sending the **Policyholder**, at its most recent address in **Our** records, a [seven (7)] day notice of **Our** intent to cancel. Any unearned premium at the time of a cancellation will be promptly calculated and returned to the **Policyholder** on a pro-rata basis, but the return of the unearned premium is not a condition of cancellation. A change or termination in this benefit will not affect a claim that begins while this benefit is in force.]

AB26-XX]

[**TRAVEL ASSISTANCE**

Travel Assistance will be available to the following **Insured Persons** when they are traveling [[100 miles] or more from their **Principal Residence] [**outside of the U.S.]: [the **Primary Insured Person** and his or her **Spouse** [/**Domestic Partner**] and/or **Child(ren)**, if covered under this **Policy**.] [the **Primary Insured Person** and his or her **Spouse [**/**Domestic Partner]** and/or **Child(ren)** if the **Spouse** [/**Domestic Partner**] and/or **Child(ren)** are with the **Primary Insured Person** while he or she is covered under this **Policy**. The **Spouse** [/**Domestic Partner**] and/or **Child(ren)** will not be covered while making a trip without the **Primary Insured Person**.] The transportation and/or services provided under **Travel Assistance** must be pre-authorized by **Us**. Under this **Policy**, **Travel Assistance** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

  Medical Evacuation
  If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care in accordance with **Western Medical Standards**, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**.

  For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider. [The maximum amount **We** will pay for this benefit is [$50,000.00].]

[Medical Services
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider duly licensed to provide such services or care in the jurisdiction where the treatment and care are delivered, **We** will pay the lesser of **Our** negotiated rate with such facility or provider, if **We** have a negotiated rate, or the **Reasonable and Customary** expenses incurred by the **Insured Person** [subject to a deductible of $[100.00]], provided that the first treatment or service occurs within [thirty (30)] days of the **Injury** or onset of **Illness**, and the medical expenses are incurred within [365 days] of the **Injury** or onset of **Illness**. **We** must be contacted within [twenty-four (24) hours] of the **Injury** or onset of **Illness** for benefits to be payable.

In addition to exclusions #1 and #2 [and #8] of the TRAVEL ASSISTANCE EXCLUSIONS section below, **We** will not pay for expenses for medical services: 1) that the **Insured Person** is not legally obligated to pay; 2) that are not **Medically Necessary** for the treatment or care of the **Injury** or **Illness**; 3) that are covered by Medicare; [a group health insurance plan sponsored by the **Policyholder**;] [or any other insurance of any kind;] Workers' Compensation, the Defense Base Act, or any other similar Federal or State mandated plan; 4) that are incurred at a Federal, Veterans, State, or Municipal hospital for which the **Insured Person** is not liable; 5) for cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Injury** or **Illness**; 6) for **Custodial Services**; 7) which are more than **Reasonable and Customary**[.][;][8) for any **Pre-Existing Condition** for [365 days] from the earlier of the enrollment or effective date of coverage;][9) for medical treatment or services provided in the United States or its territories.]

For the limited purpose of determining **Our** liability, **We** have the sole right to determine what is **Reasonable and Customary**. [The maximum amount **We** will pay for this benefit is [$5,000.00].]]

Assisted Repatriation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to his or her **Principal Residence**, or to his or her residence in the country where he or she is currently assigned (at his or her option), in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered. [The maximum amount **We** will pay for this benefit is [$25,000.00].]

Post-Recovery Repatriation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending **Physician**. The upgrade will be subject to **Our** sole discretion. [The maximum amount **We** will pay for this benefit is [$10,000.00].]

Return of Remains
If an **Insured Person** dies while on a **Covered Trip**, **We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable. [The maximum amount **We** will pay for this benefit is [$5,000.00].]

Visit to Hospital
If an **Insured Person** is scheduled to be hospitalized for more than [seven (7)] consecutive days while on a **Covered Trip**, **We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Insured Person** to visit the **Insured Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable. [The maximum amount **We** will pay for this benefit is [$5,000.00].]

Return of Child
If an **Insured Person** is traveling with a **Child(ren)**, who is under [nineteen (19)] years of age or a **Child(ren)** who prior to age [nineteen (19)] became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Insured Person** for support and maintenance, while on a

Covered Trip, and due to the **Illness** or **Injury** to the **Insured Person**, such **Child(ren)** is left unattended, **We** will arrange for, and cover the cost of, the transport of the **Child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Insured Person**, and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Child(ren)** and attendant, if applicable, for benefits to be payable. [The maximum amount **We** will pay for this benefit is [$5,000.00] per **Child** and [$5,000.00] per attendant.]

Return of Companion
If an **Insured Person** is traveling with a companion while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person** the **Insured Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one-way economy class flight. **We** must pre-authorize such costs for benefits to be payable. [The maximum amount **We** will pay for this benefit is [$5,000.00].]

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide **Travel Assistance** if the **Coverage** is excluded under Section IX General Exclusions of the **Policy**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from [the deliberate ingestion of a [poison,] [fume,] [noxious chemical substance][;][or][the use of a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.];]

   [the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions];
3. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with **Western Medical Standards**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Insured Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Insured Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or ASSISTED REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
7. **We** did not pre-authorize the transportation and/or services;
8. [the **Injuries** or **Illness** resulted in whole or in part from the **Insured Person** being intoxicated. An **Insured Person** will be conclusively presumed to be intoxicated if, on or about the time of the incident which required medical treatment, the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle. A report from a law enforcement officer, medical provider or any similar report will be considered proof of the **Insured Person's** intoxication.]

- **[TRAVEL ASSISTANCE LIMITATIONS**

Aggregate Limit of Liability per Covered Accident
[$500,000]]

- **TRAVEL ASSISTANCE DEFINITIONS**

For purposes of **Travel Assistance** only, the following definitions apply:

Covered Trip means when an **Insured Person** is traveling more than [[100] miles from his or her **Principal Residence**] [outside of the U.S.] and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

Illness or **Ill** means a sickness or disease which impairs normal functions of the body.

[Medically Necessary means essential for diagnosis, treatment or care of the **Injury** or **Illness** for which it is prescribed or performed; meets generally accepted standards of medical practice; and is ordered by a medical provider within the scope of his or her license.]

[Pre-Existing Condition means a condition for which the **Insured Person** has sought or received medical advice or treatment, or for which medical treatment was recommended, during the [six (6)] months immediately preceding the earlier of the enrollment or effective date of coverage under this **Policy**, subject to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and its regulations.]

Principal Residence means the legal domicile of the **Insured Person**.

[Reasonable and Customary means the most common charge made by other hospitals, medical facilities, clinics, and medical providers in the same region or area of the world as the treatment or services provided. If the most common expense for a treatment or service can not be determined, **We** will determine Reasonable and Customary based upon: 1) complexity involved; 2) degree of professional skill required; and 3) any other pertinent factors.]

Western Medical Standards means generally accepted medical standards comparable to those in the United States, [or Canada] [or Western Europe].

For the purpose of **Travel Assistance**, if there are any differences in the definition of a term between **Travel Assistance** and the **Policy**, the definition in **Travel Assistance** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

[Right of Recovery
We have the right to recover any benefits that **We** have paid under **Travel Assistance** if the **Policyholder** or **Insured Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Insured Person** that were covered under **Travel Assistance**. **We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Insured Person** for transportation services and/or expenses, which were not covered under **Travel Assistance**.]

[Excess Coverage
Our obligation to pay the **Policyholder** or **Insured Person** under **Travel Assistance** will be excess of any other insurance which the **Policyholder** or **Insured Person** has with respect to the expenses covered under **Travel Assistance**.]

Reservation of Rights
We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services [or in any country for which a travel warning has been issued by the Department of State of the United States of America].

[Exempted Countries
This Travel Assistance Plan is not available in the following countries: [named countries]. **We** further reserve **Our** rights to modify this list upon [ten (10)] days notice to the **Policyholder**.]

Scope
[Covered transportation expenses will be limited to air and marine conveyance.]

Illness, as covered under **Travel Assistance**, is solely covered under **Travel Assistance**, and in no way supercedes or modifies the other **Coverages** provided under this **Policy**. All other **Coverages** provided under this **Policy** are available only as a result of a **Covered Injury**.

[To contact **Us** regarding **Travel Assistance**, the **Insured Person** must call [1-866-670-6693] from the U.S. or Canada; and collect from anywhere else in the world at [+1-973-630-6693].]

AB27-XX]

[**TRAVEL ASSISTANCE REIMBURSEMENT**

Travel Assistance Reimbursement will apply to the following **Insured Persons** when they are traveling [[100 miles] or more from their **Principal Residence**] [outside of the U.S.]: [the **Primary Insured Person** and his or her **Spouse**

[/**Domestic Partner**] and/or **Child(ren)**, if covered under this **Policy**.] [the **Primary Insured Person** and his or her **Spouse**[/**Domestic Partner**] and/or **Child(ren)** if the **Spouse**[/**Domestic Partner**] and/or **Child(ren)** are with the **Primary Insured Person** while he or she is covered under this **Policy**. The **Spouse**[/**Domestic Partner**] and/or **Child(ren)** will not be covered while making a trip without the **Primary Insured Person**.] Under this **Policy**, **Travel Assistance Reimbursement** consists of the following:

- **TRAVEL ASSISTANCE REIMBURSEMENT BENEFITS**

  Medical Evacuation
  If an **Insured Person** was **Injured** or **Ill** on a **Covered Trip** and had to be transported to a hospital or medical facility which could treat the **Insured Person**'s medical condition in accordance with generally accepted medical standards of the United States of America [or Canada] [or Western Europe], **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** for such transportation, including special personnel and/or equipment. If **We** determine that a closer hospital or medical facility could have provided medical care consistent with the generally accepted medical standards of the United States of America, [or Canada] [or Western Europe], **We** will reimburse the **Policyholder** for the expenses which would have been incurred had the **Insured Person** been transported to that hospital or medical facility, if the cost of transportation would have been less than the actual expenses incurred. [In no case will **We** pay more than [$50,000.00].]

  Assisted Repatriation
  If an **Insured Person** was **Injured** or **Ill** on a **Covered Trip**, and had to be repatriated to his or her **Principal Residence** or to the country where he or she was assigned, **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** for the non-scheduled commercial air flight, or the additional reasonable expenses incurred for the regularly scheduled air flight, including special personnel and/or equipment, if applicable. (Paragraphs [3] and [4] under TRAVEL REIMBURSEMENT EXCLUSIONS will not apply to this benefit.) If **We** determine that alternative transportation could have been provided without compromising the health of the **Insured Person**, **We** will reimburse the **Policyholder** for the reasonable expenses, or additional reasonable expenses, if applicable, which would have been incurred had the alternative transportation been provided to the **Insured Person**, if the cost of such transportation would have been less than the actual expenses incurred. [In no case will **We** pay more than [$25,000.00].]

  Post-Recovery Repatriation
  If an **Insured Person** was **Injured** or **Ill** on a **Covered Trip**, and had to be repatriated to his or her **Principal Residence**, or to the country where he or she was assigned due to the **Injury** or **Illness**, **We** will reimburse the **Policyholder** for the reasonable additional expenses incurred by the **Policyholder** to change the original travel date on the return flight and/or an upgrade in the seating. [In no case will **We** pay more than [$10,000.00].] (Paragraphs [3] and [4] under TRAVEL ASSISTANCE REIMBURSEMENT EXCLUSIONS will not apply to this benefit.)

  Return of Remains
  If an **Insured Person** died while on a **Covered Trip**, **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** for local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. [In no case will **We** pay more than [$5,000.00].]

  Visit to Hospital
  If an **Insured Person** was scheduled to be hospitalized for more than [seven (7)] consecutive days while on a **Covered Trip**, **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** for the round trip transportation of the person chosen by the **Insured Person** to visit the **Insured Person** while he or she was hospitalized. [In no case, will **We** pay more than [$5,000.00].]

  Return of Child
  If an **Insured Person** was traveling with a **Child(ren)**, who is under [nineteen (19)] years of age or a **Child(ren)** who prior to age [nineteen (19)] became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Insured Person** for support and maintenance, while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person**, such **Child(ren)** is left unattended, **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** to transport such **Child(ren**) to

the location chosen by the **Insured Person**, including the reasonable expenses incurred for an attendant, if applicable. [In no case will **We** pay more than [$5,000.00] per **Child** and [$5,000] per attendant.]

Return of Companion
If an **Insured Person** was traveling with a companion while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person** the **Insured Person** cannot complete the **Covered Trip** as scheduled, **We** will reimburse the **Policyholder** for the additional reasonable expenses incurred by the **Policyholder** to change the travel date of the companion's return flight. [In no case will **We** pay more than [$5,000.00].]

[Access Fee
We will reimburse the **Policyholder** for the expenses the **Policyholder** incurs to provide access to travel assistance services. [In no case will **We** pay more than [$50,000.00].]]

- **TRAVEL ASSISTANCE REIMBURSEMENT EXCLUSIONS**

  We will not reimburse the **Policyholder** for expenses incurred if such expenses would have been excluded as a **Covered Loss** under the **Policy**, or if:

  1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;

  2. the **Injuries** or **Illness** requiring medical services resulted from

  [the deliberate ingestion of a [poison,] [fume,] [noxious chemical substance][;][or][the use of a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.];]

  [the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions];

  3. based upon **Our** review of a claim, **We** determine that the medical care in the hospital, medical facility, or clinic or by the medical provider was and would have been in accordance with generally accepted medical standards of the United States of America, [or Canada] [or Western Europe];

  4. based upon **Our** review of a claim, **We** determine that it was not medically necessary to transport the **Insured Person** to another hospital or medical facility.

  5. [the **Injuries** or **Illness** resulted in whole or in part from the **Insured Person** being intoxicated. An **Insured Person** will be conclusively presumed to be intoxicated if, on or about the time of the incident which required medical treatment, the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle. A report from a law enforcement officer, medical provider or any similar report will be considered proof of the **Insured Person's** intoxication.]

- [**TRAVEL ASSISTANCE REIMBURSEMENT LIMITATIONS**

  Aggregate Limit of Liability per Covered Accident
  [$500,000]]

- **TRAVEL ASSISTANCE REIMBURSEMENT DEFINITIONS**

  For purposes of **Travel Assistance Reimbursement** only, the following definitions apply:

  Covered Trip means when an **Insured Person** is traveling more than [[100] miles from his or her **Principal Residence**] [outside of the U.S.] and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE REIMBURSEMENT EXCLUSIONS set forth above.

  Illness or **Ill** means a sickness or disease, which impairs normal functions of the body.

  Principal Residence means the legal domicile of the **Insured Person**.

- **TRAVEL ASSISTANCE REIMBURSEMENT - OTHER PROVISIONS**

  [**Excess Coverage**

Our obligation to reimburse the **Policyholder** under **Travel Assistance Reimbursement** will be excess of any other insurance which the **Policyholder** or **Insured Person** has with respect to the expenses covered under **Travel Assistance Reimbursement**.]

[Right of Recovery
We have the right to recover any benefits, which **We** have paid to the **Policyholder** under **Travel Assistance Reimbursement**, if the **Policyholder** recovers any money from a third party for the expenses incurred by the **Policyholder** that were covered under **Travel Assistance Reimbursement**. **We** will be reimbursed from such recovery, and **We** will have a lien against that recovery.]

Scope
[Covered transportation expenses will be limited to air and marine conveyances.]

Illness, as covered under **Travel Assistance Reimbursement**, is solely covered under **Travel Assistance Reimbursement**, and in no way supercedes or modifies the other **Coverages** provided under this **Policy**. All other **Coverages** provided under this **Policy** are available only as a result of a **Covered Injury**.

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SECTION VIII – LIMITATIONS

Limitation on Multiple Covered Losses.

We will pay only one benefit, the largest benefit, if [a **Primary Insured Person**] [an **Insured Person**] sustains more than one loss as a result of the same **Accident**.

Limitation on Multiple Benefits.

The most **We** will pay for the following benefits, in total, is the [**Primary Insured Person's**] [**Insured Person's**] **Principal Sum**, if the[**Primary Insured Person**] [**Insured Person**] can recover benefits under more than one of these: **Accidental Death Benefit**, [**Accidental Dismemberment** [**and Covered Loss of Use**] [**and Plegia**] **Benefit**,] [**Coma Benefit**,] [**Permanent and Total Disability Benefit**,] [**HIV Occupational Accident Benefit**,] [**In-Hospital Indemnity Benefit**] as a result of the same **Accident**.

Limitation on Multiple Hazards.

We will pay only one benefit, the largest benefit [unless there is a specific written exception in the **Policy**], if [**a Primary Insured Person**] [**an Insured Person**] sustains a **Covered Loss** that is covered under more than one **Hazard**.

[**Aggregate Limit**.

We will not pay more than the **Aggregate Limit of Liability** stated in the Schedule.]

SECTION IX – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

- [suicide or any attempt at suicide [or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**[with regard to **Accidental Dismemberment [and Loss of Use][and Plegia] Benefits** only**]]** [including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of autoeroticism or auto-erotic asphyxiation];]

- [war or any act of war, whether declared or undeclared[occurring in the following geographic locations [named countries] only];]
- [involvement in any type of active military service[(Reserve or National Guard active duty training is not excluded, unless it extends beyond [thirty-one (31) consecutive days].)] [(For purposes of this exclusion, orders to active military service for [sixty (60) days] or less will not be considered involvement in active military service.)] [(This exclusion does not apply to the first [sixty (60) consecutive days] of active military service.)];]
- illness or disease [,regardless of how contracted,]; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; [except for **Accidental** ingestion of contaminated foods];
- [participation in the commission or attempted commission of [a crime,] [any felony,] [an assault,] [insurrection] [or] [riot];]
- [[parasailing,] [bungee jumping,] [heli-skiing,] [scuba diving] [or any other extra-hazardous activity];]
- [[being intoxicated while operating a motor vehicle.]

  [being intoxicated.]

  1. [A **Primary Insured Person**] [An **Insured Person**] will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.

  2. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the [**Primary Insured Person's**] [**Insured Person's**] intoxication.]
- [the deliberate ingestion of a [poison,] [fume,] [noxious chemical substance][;][or][the use of a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.];]

  [the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions;]
- [travel or flight in any aircraft except to the extent stated in the **Hazards** Section;]
- [a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**;]
- [alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a **Physician** operating within his or her scope of authority.]

SECTION X – TERMINATION OF POLICY

Termination by the Policyholder.

The **Policyholder** may terminate this **Policy [**on the first renewal date or at any time after that date] by delivering to **Us** a written notice to end this **Policy** at least [thirty (30)] days in advance of such termination (unless **We** agree to an earlier date).

Upon receipt of such written notice, **We** will calculate and return the unearned premium, if any, using a pro-rata table. The **Policyholder** will send **Us** any additional amounts owed, if any, between the **Policy's** paid to date and the official date of termination.

Termination by Us.

We may terminate this **Policy** by giving the **Policyholder** at least [thirty (30)] days written notice of **Our** intent to terminate (unless the **Policyholder** agrees to an earlier date). Such written notice will state the exact date the **Policy** will terminate.

[We may also end this **Policy** for nonpayment of premium on any premium due date, if the payment is not received prior to the end of the **Grace Period**. **We** will mail a written notice of such termination to the **Policyholder's** last address shown in **Our** records.]

[This **Policy** will automatically terminate on the last day of the **Grace Period** if the **Policyholder** fails to pay all premiums due by the last day of the **Grace Period**.]

If **We** or the **Policyholder** terminate this **Policy**, **Coverage** will end when it is 12:01 AM, Standard Time, on the day following the last day of **Coverage**, at the **Policyholder's** address.

If this **Policy** is terminated, the termination will not affect a claim incurred prior to the termination date of the **Policy**.

SECTION XI – CLAIMS PROVISIONS

Notice. The **Primary Insured Person** or the beneficiary, or someone on their behalf, must give **Us** written notice of the **Covered Loss** within twenty (20) days of such **Covered Loss**. The notice must name [the **Insured Person** who sustained the **Injury**,] the **Primary Insured Person**, and the **Policy** Number. To request a claim form, the **Primary Insured Person** or the beneficiary, or someone on their behalf may contact **Us** at [866-583-2233.] The notice must be sent to the Claims Department, Atlantic Specialty Insurance Company, [P.O. Box 1009, Morristown, NJ 07962-1009], or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

Claim Forms. We will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss**.

Proof of Covered Loss. Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss**, and the proof was provided as soon as reasonably possible.

Time of Payment. We will pay claims for all **Covered Losses**, other than **Covered Losses** for which this **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

Recipient of Payment.

1. Loss of Life of a **Primary Insured Person**. **Covered Losses** resulting from the **Primary Insured Person's** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as the **Primary Insured Person**, **We** will pay the benefit to [the beneficiary named by the **Primary Insured Person** for the **Policyholder's** Group Life Insurance policy. If there is no beneficiary named by the **Primary Insured Person** for the **Policyholder's** Group Life Insurance policy, or the named beneficiary predeceases or dies at the same time as the **Primary Insured Person**, **We** will pay the benefit to] [the **Primary Insured Person's** survivors in the following order:

- **a.** the **Primary Insured Person's Spouse**[or **Domestic Partner**];
- **b.** the **Primary Insured Person's** child(ren);
- **c.** the **Primary Insured Person's** parents;
- **d.** the **Primary Insured Person's** brothers and sisters;
- **e.**] the **Primary Insured Person's** estate.

2. [Loss of Life of a **Covered Dependent**. **Covered Losses** for the death of a **Covered Dependent** will be paid to the **Primary Insured Person**. If the **Primary Insured Person** pre-deceases or dies at the same time as the **Covered Dependent**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to the **Primary Insured Person's** estate.

3.] All Other Claims. Benefits are to be paid to the [**Primary Insured Person**][**Insured Person**]. [He or she may direct in writing that all, or part of the **Accident Medical Expense Benefit**, if applicable, will be paid directly to the party who furnished the service. The direction may be changed by the [**Primary Insured Person**][**Insured Person**] at any time up to the filing of the proof of **Covered Loss**].

[**4.** If a **Foreign National** is entitled to benefits for a **Covered Loss** and **We** are unable to make payment directly to him or her because of legal restrictions in the country or jurisdiction where such **Foreign National** is located, **We** will either: (1) pay the benefits to a bank account owned by the **Foreign National** in the United States of America; or (2) if no such bank account is established or maintained, **We** will pay the benefits to the **Policyholder** on behalf of the **Foreign National**. It will then be the responsibility of the **Policyholder** to remit the benefit to such **Foreign National**. Payment of the benefit to the **Policyholder** will release **Us** from any further liability to the **Foreign National**. If the **Policyholder** does not remit the payment to the **Foreign National**, the **Policyholder** will indemnify **Us** and hold **Us** harmless against any and all liability incurred by **Us** including, but not limited to, interest, penalties, and attorneys' fees in connection with, arising or resulting from such failure to remit payment. The **Policyholder** will not be considered the beneficiary under the **Policy** if payment is made to the **Policyholder** in accordance with this provision.]

Physical Examination and Autopsy. We have the right to examine [a **Primary Insured Person**] [an **Insured Person**] when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

Choice of Service Provider. The [**Primary Insured Person**] [**Insured Person**] has the sole right to choose his or her duly licensed **Physician** and hospital.

[**Right to Recover Overpayments**. In addition to any rights of recovery or reimbursement provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of this **Policy**, **We** will have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to the **Insured Person** (and his or her assignee) under this **Policy** to the extent of the overpayment.]

Suit Against Us. No action on this **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina, Wisconsin and Alabama) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where the [**Primary Insured Person**] [**Insured Person**] lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

[**Arbitration.** Any contest to a claim denial under this **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the [**Primary Insured Person**] [**Insured Person**]. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the [**Primary Insured Person**] [**Insured Person**] is a resident of a state where the law does not allow binding arbitration in an insurance **Policy**, but only if this **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of lawsuit by the [**Primary Insured Person**] [**Insured Person**]].

[**ERISA Claims Fiduciary.** The **Policyholder** agrees that the **Policy** constitutes the plan and plan document under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The **Policyholder** designates **Us** [or a person or persons which **We** designate] as the claims fiduciary of this plan and gives **Us** the discretionary authority to determine eligibility for benefits and to construe the terms of the plan. The **Policyholder** agrees to comply with the disclosure and reporting requirements of ERISA regarding the plan and **Our** designation and authority as the claims fiduciary.]

SECTION XII – GENERAL PROVISIONS

Beneficiaries. The **Primary Insured Person** has the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. The **Primary Insured Person** may change the beneficiary at any time unless he or she has assigned the interest in the **Policy**. In such case, the person to whom he or she has assigned the interest in this

Policy may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us**.

Change or Waiver. A change or waiver of any terms or conditions of this **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under this **Policy** will not be deemed as a waiver of such rights in the same or future situations.

Clerical Error. A clerical error or omission will not increase or continue a **Primary Insured Person's Coverage**, which otherwise would not be in force. If a **Primary Insured Person** applies for insurance for which he or she is not eligible, **We** will only be liable for any premiums paid to **Us**.

Conformity with Statute. Terms of this **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

Entire Contract. This **Policy**, together with any riders, endorsements, amendments, applications, completed enrollment materials, and attached papers, if any, make up the entire contract between the **Policyholder** and **Us**. In the absence of fraud, all statements made by the **Policyholder** or any **Insured Person** will be considered representations and not warranties. No written statement made by an **Insured Person** will be used in any contest unless a copy of the statement is furnished to the **Insured Person** or his or her beneficiary or personal representative.

Primary Insured Person Certificates. We will give to the **Policyholder** a **Certificate**, in either paper or electronic format, for their **Primary Insured Persons**, where required by state law. The **Policyholder** will either give or make these **Certificates** available to the **Primary Insured Persons**. Such **Certificate** will contain a summary of terms that affect benefits.

Policyholder Records/Audit. The **Policyholder** will keep a record of the **Coverage**, premium and other pertinent administrative information for each **Primary Insured Person**. **We** may examine these records at reasonable times while the **Policy** is in force and for six years after the termination of the **Policy**. **We** reserve the right to charge or refund premium, as applicable. The **Policyholder** will report to **Us**, within a reasonable time, all changes in information regarding a **Primary Insured Person**. [The **Policyholder** will indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the record keeping function. In addition, the **Policyholder** will be liable for any retroactive premium.]

[**Renewal.** This **Policy** will automatically renew for an additional twelve-month period unless either party expresses its intent not to renew as specified by **Policy** termination provisions.]

[**Assignment of Interest.** A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.]

[Incontestability. The validity of this **Policy** will not be contested after it has been in force for two (2) years from the **Policy** Effective Date, except as to nonpayment of premiums.]

[**Newly Acquired Aircraft.** If the **Policyholder** acquires ownership or possession under a lease agreement of additional aircraft, and the **Policyholder** notifies **Us** of such acquisition or possession [within [sixty (60)] days after] [upon the first Anniversary Date of the **Policy** following] the delivery of the **Newly Acquired Aircraft**, the aircraft **Coverage** provided in Section IV **Hazards**, will also apply to the **Newly Acquired Aircraft** upon delivery of such aircraft to the **Policyholder**.

If the **Policyholder** does not notify **Us** of a **Newly Acquired Aircraft [**within [sixty (60)] days after] [upon the first Anniversary Date of the **Policy** following] its delivery, or does not pay the additional premium required, if any, **Coverage** for the **Newly Acquired Aircraft** will terminate. However, the **Policyholder** will be liable for the payment of any premium required for the period such **Coverage** was in effect.]

[**Newly Acquired Corporation.** If the **Policyholder** acquires a corporation through stock purchase, exchange of stock or otherwise, and notifies **Us** of such acquisition [within [ninety (90)] days] [upon the first Anniversary Date of the **Policy]** thereafter, the eligible employees of the **Newly Acquired Corporation** will be insured under this **Policy** as of the effective date of such acquisition.

If the **Policyholder** does not notify **Us** and provide **Us** with the underwriting information necessary for **Us** to determine the amount of additional premium required, if any, [within the [ninety (90)] days] [upon the first Anniversary Date of the **Policy** following the acquisition**]**, or does not pay such additional premium, if any, as required, the **Coverage** for the employees of the **Newly Acquired Corporation** will terminate. However, the **Policyholder** will be liable for the payment of any premium required for the period such **Coverage** was in effect.

[Note: The above reporting provision only applies to corporations with more than [200] employees. For corporations with less than [200] employees, reporting of such acquisition will not be required, and **Coverage** will be automatic for the duration of the **Policy** term.]]

SECTION XIII – DEFINITIONS

- **Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.
- **Active** or **Actively at Work** describes an employee who is able and available for active performance of all of his or her regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered actively at work provided the employee is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.
- **[Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in this **Policy**. For purposes of the Aggregate Limit of Liability provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause [occurring within a [one (1)] day period] and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each **Insured Person**, **We** will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.]
- [**Chartered Aircraft** means an aircraft operated by a company with an air carrier or commercial operating certificate issued by the Federal Aviation Administration or the equivalent certificate issued by a foreign government, which the **Policyholder** has the right to use for no more than [ten (10)] consecutive days and/or for no more than [fifteen (15)] days in a [one (1)] year period.]
- [**Controlled** by, as used in the **Hazards** Section, means the **Policyholder** has the right to use a block of aircraft flight time for [25] or more hours in a [one (1)] year period or for [100] hours or more without a specified term, from a company which is in the business of providing aircraft for private use. A **Chartered Aircraft** will not be considered **Controlled** by the **Policyholder**.]
- **Coverage(s)** means the event or events described in the **Hazards** Section **[**and Additional Coverages Section]of this **Policy** to which benefits and additional benefits apply. The **Hazards** [and Additional Coverages] are listed in the Schedule.
- **Covered Accident** means an **Accident** that results in a **Covered Loss**.
- **Covered Injury** means an **Injury** directly caused by an **Accident**, which is independent of all other causes, results from a **Covered Accident**, occurs while the **Insured Person** is insured under this **Policy**, and results in a **Covered Loss**.
- **Covered Loss** means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury**, and for which benefits are payable under this **Policy**.

- **Dependent** means a **Primary Insured Person's Spouse** [/**Domestic Partner**] and **Dependent Child(ren)**, as defined in this Section. [The **Dependent** will only be a **Covered Dependent** if the **Primary Insured Person** selects a **Plan** covering his or her **Dependents**.]

- **Dependent Child(ren)**, if used in this **Policy**, means those unmarried **Child(ren)** of the **Primary Insured Person**, [and] [those unmarried **Child(ren)** of his or her **Spouse]** [, and those unmarried **Child(ren)** of the **Primary Insured Person's Domestic Partner** [as defined in the **Policyholder's** [medical] plan as on file with and approved by **Us**]] who rely on the **Primary Insured Person** for [more than 50% of] their support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap. [The **Dependent Child(ren)** will only be **Covered Dependent Child(ren)** if the **Primary Insured Person** selects a **Plan** covering his or her **Dependent Child(ren)**.]

- [**Domestic Partner** means [a person who qualifies as a domestic partner under the **Policyholder's** written procedures as on file with and approved by **Us**.] [a person who qualifies as a domestic partner under the law of the state of residence.] [a person as defined in the **Policyholder's** [medical] plan as on file with and approved by **Us**.]]

- [**Domestic Partner**
  To qualify as a domestic partner, the following requirements must be met:
  1. [the **Primary Insured Person** and the domestic partner must have an intimate, committed relationship of mutual caring, and have agreed to be responsible for each other's welfare;]
  2. [the **Primary Insured Person** and the domestic partner must have lived together in such a relationship for a period of not less than six consecutive months at the same residence address;]
  3. [the **Primary Insured Person** and the domestic partner must both be at least 18 years of age;]
  4. [neither the **Primary Insured Person** nor the domestic partner are legally married;]
  5. [the **Primary Insured Person** and the domestic partner are not related by blood or adoption;]
  6. [the **Primary Insured Person** and the domestic partner are each other's sole domestic partner and intend to remain so indefinitely; and]
  7. [the **Primary Insured Person** and the domestic partner must be of the same sex, and if applicable law permitted, would be married.]

  The existence of the relationship between the domestic partner and the **Primary Insured Person** must be evidenced by:
  1. [the domestic partner being named as the primary beneficiary in the event of the **Primary Insured Person's** death under the **Primary Insured Person's** retirement plan or 401(k) plan, if the **Primary Insured Person** maintains such a plan;]
  2. [at least one of the following:
     a. designation of the domestic partner as a primary beneficiary under the **Primary Insured Person's** will; or
     b. designation of the domestic partner as a primary beneficiary for the **Primary Insured Person's** life insurance;]
  3. [at least one of the following:
     a. joint ownership of real estate (whether by mortgage, lease or deed);
     b. joint ownership of a motor vehicle; or
     c. joint ownership of a bank account; and]
  4. [a completed, active certification of domestic partner status form on file with the **Policyholder**.]

  To have coverage, the **Primary Insured Person** will not have completed a Termination of Domestic Partner status form with respect to the domestic partner who is to be covered under the **Policy**.]

- [**Foreign National** means a person who is a citizen of a country or jurisdiction other than the United States of America and who is not a resident of the United States of America.]

- **Injured**, **Injury or Injuries** means bodily harm or bodily damage.

- **Insured Person** means any person who has insurance under the terms of this **Policy**. It includes the **Primary Insured Person**[,and his or her **Spouse**[**/Domestic Partner**] and/or **Dependent Child(ren)** if the **Primary Insured Person** selects a **Plan** covering his or her **Spouse** [**/Domestic Partner**] and/or **Dependent Child(ren)]**.
- [**Owned Aircraft** means an aircraft in which the **Policyholder** [or a related company] has legal or equitable title. Fractional ownership in a company which is in the business of providing aircraft for private use will be deemed to be equitable title in the aircraft used by the **Policyholder**.]
- **Physician** means a person who is licensed to practice medicine in the jurisdiction in which the medical service or treatment is performed and is acting within the scope of his or her license.
- **Plan** means the plan design as described in the Schedule.
- **Policy** means this Group **Accident** Insurance **Policy**.
- **Policyholder** means the group named on the front page of this **Policy**.
- **Primary Insured Person** means an individual who [has an employment relationship with the **Policyholder**;] is eligible for coverage under this **Policy** as provided in the Eligibility of **Primary Insured Persons** part of Section I[; and who completes the enrollment material].
- [**Service Waiting Period** means the continuous length of time a person is required to be employed by the **Policyholder** prior to being covered under this **Policy**.]
- **[Specialized Aviation Activity** means an aircraft while it is being used for one or more of the following activities:

  [acrobatic or stunt flying]
  [aerial photography]
  [banner towing]
  [bird or fowl herding]
  [crop dusting]
  [crop seeding]
  [crop spraying]
  [endurance tests]
  [exploration]
  [fire fighting]
  [flight on a rocket-propelled or rocket launched aircraft]
  [flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted]
  [hangliding]
  [hunting]
  [parachuting or skydiving]
  [pipe line inspection]
  [power line inspection]
  [racing]
  [skywriting]
  [test or experimental purpose]]
- **Spouse**, if used in this **Policy**, means the **Primary Insured Person's** legally married **Spouse** [under age 70]. [A **Spouse** will only be a **Covered Spouse** if the **Primary Insured Person** selects a **Plan** covering his or her eligible **Spouse**.]
- [**Under lease**, as used in the **Hazards** Section, means an aircraft which the **Policyholder** does not own but has the right to use, under a written agreement, for more than [ten (10)] consecutive days and/or for more than [fifteen (15)] days in a [one (1)] year period. A **Chartered Aircraft** will not be considered **Under lease**.]
- **We**, **Us**, and **Our** refers to Atlantic Specialty Insurance Company.

[Policyholder: **[ABC Company]**
Policy Number: **[123-456-789]**
Policy Effective Date: **[January 1, 2007]]**

[Underwritten by: **[Atlantic Specialty Insurance Company]**

GROUP [BASIC][BUSINESS TRAVEL][VOLUNTARY] ACCIDENT CERTIFICATE OF INSURANCE

FOR

EMPLOYEES OF [POLICYHOLDER]

THIS INSURANCE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY.

IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS.

[Atlantic Specialty Insurance Company]
[OneBeacon Insurance Company]
[1 Beacon Lane
Canton, MA 02021-1030]

POLICYHOLDER: **[ABC Company]**

POLICY NUMBER: **[1234567]**

[COVERED SUBSIDIARIES OR AFFILIATED COMPANIES **[Names of Companies]]**

The insurance evidenced by this Certificate provides Accident insurance only. It does not provide Coverage for sickness. This Certificate describes the main features of the Policy, but the Policy is the only contract under which benefit payments are made. If there is an inconsistency between the Certificate and the Policy, the Policy will govern.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT

CERTIFICATE OF INSURANCE

Table of Contents

SECTION I – ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

CERTIFICATE HOLDER.

Class	Description
[1]	[All **Active** [full-time][and part-time]employees of the **Policyholder** working a minimum of [30] hours per week [who have completed the required **Service Waiting Period** indicated below] [and who have completed enrollment material on file with the **Policyholder**].]
[2]	[All **Active** [Union][non-Union] employees of the **Policyholder** [who have completed the required **Service Waiting Period** indicated below] [and] [who have completed enrollment material on file with the **Policyholder**].]
[3]	[As determined by the **Policyholder's** written human resource policy for benefit eligibility, with respect to Accident coverage, as of the effective date of the **Policy** [who have completed the required **Service Waiting Period** indicated below] [and] [who have completed enrollment material on file with the **Policyholder**].]

[If **You** sustain an **Injury** resulting in a **Covered Loss**, and **You** are covered under more than one Class, only one benefit will be paid, the largest benefit.]

Effective Date. [A. If **You** are hired prior to [January 1, 2007]:
[January 1, 2007], provided the completed enrollment material is received by the **Policyholder** on or prior thereto.

B. If **You** are hired on or after [January 1, 2007]:
[on the first day of the month following the date the completed enrollment material is received by the **Policyholder**] [upon completion of the required **Service Waiting Period** indicated below, provided the completed enrollment material is received by the **Policyholder** prior thereto] [on the first day of the month following completion of the required **Service Waiting Period** indicated below, provided the completed enrollment material is received by the **Policyholder** prior thereto].]

[A. If **You** are hired prior to [January 1, 2007]:
the later of the **Policy** effective date or upon completion of the required **Service Waiting Period**, if any, indicated below.

B. If **You** are hired on or after [January 1, 2007]:
the later of the first day of **Active** work or upon completion of the required **Service Waiting Period**, if any, indicated below.]

[A. If **You** are hired prior to [January 1, 2007]:
Your first day of **Active** work following the effective date of the **Policy**.

B. If **You** are hired on or after [January 1, 2007]:
Your first day of **Active** work following **Your** date of hire.]

[If **You** are not **Actively at Work** on **Your** Effective Date of coverage, coverage will begin on **Your** first full day of **Active** work following **Your** Effective Date.]

[Service Waiting Period. [None.] [[thirty (30)] days of **Active** continuous service.] [As per the **Policyholder's** then written plan.]]

Termination Date. [Your coverage terminates at the end of the [month][period] for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;

2. **You** cease to be eligible for coverage;

3. **You** fail to pay the required premium, if **You** are so required [;][.]
4. [**You** reach age [70]][;][.]
5. [**You** retire.]]

[**Your** coverage automatically terminates on the earliest of:

1. the date the **Policy** is terminated;
2. the date **You** cease to be eligible for coverage;
3. the expiration date of the period for which required premium has been paid for **You**;
4. the date **You** fail to pay the required premium, if **You** are so required[;][.]
5. [the date **You** reach age [70]][;][.]
6. [the date **You** retire.]]

[If **You** have received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written policy, **Your** insurance under the **Policy** will continue, provided the required premiums are paid. This extension of coverage is subject to all of the termination provisions of the **Policy** with the exception of number 2. above.]

[**Conversion Coverage**. If **Your** insurance ceases for reasons other than termination of the **Policy** [or non-payment of premium], **You** are entitled to purchase **Conversion Coverage** under a conversion group policy. [**You** may also purchase **Conversion Coverage** for **Your Dependents**, if such **Dependents** were covered under the **Policy** at the time insurance ceases.] The conversion group policy will be on **Our** approved forms and will only provide **Accidental Death Benefits** [and **Accidental Dismemberment** [and **Covered Loss of Use**][and **Plegia**] **Benefits**].

Written application for **Conversion Coverage** must be made within [sixty (60)] days of the cessation of insurance under the **Policy**. [To request an application form, **You** must [call [1-800-527-1255]] [or write to **Us** at [44 Whippany Road, Morristown, NJ 07960]].] **You** [and **Your Covered Dependents**, if applicable,] are not required to show proof of good health.

The issuance of **Conversion Coverage** is subject to the following conditions:

1. the **Principal Sum** will be the lesser of:
   a. **Your Principal Sum** under the **Policy** [, rounded to the next higher [$10,000], if not already a multiple thereof,] [, but the amount may not be less than [$50,000].] [In the event that **You** have a **Principal Sum** in an amount less than [$100,000], **You** may continue that amount or increase the amount to [$100,000].][;] Or,
   b. [$250,000];
2. the premium for the group conversion policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. coverage under the conversion group policy will take effect on the termination date of **Your** coverage under the **Policy**; and
4. when coverage under the conversion group policy becomes effective, the relationship between **You** and **Us** will be governed by that policy, including all terms and conditions, and benefits and termination dates.

[Eligibility for **Conversion Coverage** will cease when **You** attain age [seventy (70)].]

[**Conversion Coverage** is only available to **You** if **You** are a resident of the United States at the time **Conversion Coverage** is purchased.]

[**Conversion Coverage** is [not] available for residents of [named states].]

[**Covered Loss During the Conversion Coverage Application Period**. If **You** sustain an **Injury** resulting in a **Covered Loss** that would have been payable under the **Accidental Death Benefit [or Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, within the [sixty (60] day **Conversion Coverage** application period, **We** will pay the **Principal Sum** amount that would have been paid under the **Policy**. This benefit will be paid regardless of whether **You** had applied to purchase **Conversion Coverage** at the time of **Your Covered Loss**.]]

[**Portability Coverage**

If **Your** insurance ceases for reasons other than [non-payment of premium or] cancellation of the **Policy**, **You** have the right to continue **Coverage** under the **Policy**, [even if the **Policy** is subsequently canceled or terminated for any reason] [provided the **Policy** is not subsequently canceled or terminated.]

This **Portability Coverage** is subject to the following conditions:

1. written notice to **Us** of **Your** election to continue **Coverage** and the initial premium, must be received by **Us** within [sixty (60)] days of the event causing the termination of **Your** insurance, along with **Your** home and billing address, if different.

2. **You** may elect to continue the same **Principal Sum** [rounded up to the next higher [$10,000]] [to a maximum of [$250,000]][but the amount may not be less than [$50,000]]. In the event that **You** have a **Principal Sum** in an amount less than [$100,000], **You** may continue that amount or increase the amount to [$100,000]. [The maximum **Principal Sum** under this **Portability Coverage** will be [$250,000.]]

3. upon receipt of the written notice, **We** will provide **You** with a **Certificate** Endorsement to be attached to **Your Certificate of Insurance**, which will provide the Initial **Portability Coverage** Period beginning with the termination date of **Your** coverage under the **Policy**.

4. the initial premium will be based upon the Portability rates which appear in the Premium Section of the **Policy**. [**We** reserve the right to change the premium.]

[Eligibility for **Portability Coverage** will cease when **You** attain age [seventy (70)].]

[If the insurance of **Your Covered Spouse [/Domestic Partner]** ceases because of the **Your** death while **Portability Coverage** is in effect, **Your Covered Spouse [/Domestic Partner]** may apply to continue **Portability Coverage**. **Your Covered Spouse [/Domestic Partner**] will be eligible for the amount of **Principal Sum** he or she had in force under the **Portability Coverage**. Written application for continuation of **Portability Coverage** must be made within [sixty (60)] days of the cessation of **Your Covered Spouse's [/Domestic Partner's**] insurance under **Portability Coverage**.]

[**Portability Coverage** is [only] available for residents of [named states].]

[**Covered Loss During the Portability Coverage Application Period**. If **You** sustain an **Injury** resulting in a **Covered Loss** that would have been payable under the **Accidental Death Benefit [or Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, within the [sixty (60] day **Portability Coverage** application period, **We** will pay the **Principal Sum** amount that would have been paid under the **Policy**. This benefit will be paid regardless of whether **You** had applied to purchase **Portability Coverage** at the time of **Your Covered Loss**.]]

[CERTIFICATE HOLDER'S DEPENDENTS.

Eligibility. Individuals who enroll may elect to cover their eligible **Dependents**. An eligible **Dependent** includes **Your Spouse**[/**Domestic Partner**] and **Your Dependent Child(ren)**, [and] [**Your Spouse's Dependent Child(ren)]** [, and **Your Domestic Partner's Dependent Child(ren)**]. [**Your Spouse**[/**Domestic Partner**] will not be eligible as a **Dependent** if he or she is also a **Primary Insured Person** under the **Policy**.] [If **You** and **Your Spouse [/Domestic Partner]** or former **Spouse**[/**Domestic Partner**] are both **Primary Insured Persons** under the **Policy**, only one may select a **Plan** covering **Your** mutual **Dependents**.]

Effective Date. Dependent coverage begins on the later of:

1. the date **Your** coverage begins, provided **You** requested **Dependent Coverage** on **Your** enrollment materials;

2. the date **You** request to add coverage for **Your** eligible **Dependents** in the applicable benefit materials; or

3. the date he or she becomes an eligible **Dependent**.

Termination Date. [Coverage terminates at the end of the [month][period] for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;

2. **Your Dependent** ceases to be eligible for insurance;

3. **Your** coverage terminates, except in such situations where the written policy of the **Policyholder** allows **You** to continue coverage for **Your Covered Dependents**;
4. **You** fail to pay the required premium, if **You** are so required[;][.]
5. [for the **Covered Spouse[/Domestic Partner**] only, **Covered Spouse[/Domestic Partner** reaches age [70].]]

[Coverage automatically terminates on the earliest of:

1. the date the **Policy** is terminated;
2. the date **Your Dependent** ceases to be eligible for coverage;
3. the date **Your** coverage terminates, except in such situations where the written policy of the **Policyholder** allows **You** to continue coverage for **Your Covered Dependents**;
4. the expiration date of the period for which the required premium has been paid for such **Dependent**;
5. the date **You** fail to pay the required premium, if **You** are so required[;][.]
6. [for the **Covered Spouse[/Domestic Partner**] only, the date the **Covered Spouse[/Domestic Partner** reaches age [70].]]

[If **You** have received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written policy, insurance for **Your Covered Dependents** under the **Policy** may continue, provided the required premiums are paid. This extension of coverage **is** subject to all of the termination provisions of the **Policy** with the exception of number 2. above.]

[Notwithstanding the forgoing provisions, the **Policy** will conform to the **Policyholder's** written policy with respect to accident coverage with regard to eligibility for coverage, continuation of coverage, and termination of coverage as in force on the effective date of the **Policy**.]

SECTION II – SCHEDULE

HAZARDS

The following are the **Hazards** for which insurance applies:

[All Classes]	[including their **Covered Dependents**]:]
	[24 Hour **Accident** Protection, Business and Pleasure, Excluding Corporate Owned or Leased Aircraft]
[Class 1]	[and their **Covered Dependents**]:] [24 Hour **Accident** Protection while on a **Specified Trip**]

Additional Coverages

[Class 2]	[and their **Covered Dependents**]:]	[Felonious Assault Coverage]

BENEFITS

A. Principal Sum

The following are the **Principal Sums** for each Class:

[Class 1]	[An employee may purchase an amount of **Principal Sum** from a minimum of [$50,000] to a maximum of [$500,000] in increments of [$10,000]. [However, amounts applied for in excess of [$150,000] must not exceed [ten (10)] times the employee's **Base Annual Earnings***.]]
[Class 2]	[[Three (3)] times the employee's **Base Annual Earnings*** to a maximum of [$500,000].]
[Class 3]	[$100,000]
[Class 4]	[as on file with the **Policyholder** and **Us**]

[*__Base Annual Earnings__ means the employee's base annual pay [excluding overtime, bonuses, [commissions] and special compensation.]]

[The following are the **Principal Sums** for **Covered Dependents**:

[The **Principal Sum** for **Covered Dependents** will be a percentage of the employee's **Principal Sum**:

Plan Selected	**% Spouse[/Domestic Partner]**	**% Child(ren)**
Spouse[/Domestic Partner] only:	[50%]	0
Dependent Child(ren) only:	0	[15%]
Spouse[/Domestic Partner] and **Dependent Child(ren)**	[40%]	[10%]

[Maximum of [$25,000] [**Principal Sum**] [**Accidental Death Benefit**] for **Dependent Child(ren)**.]

[For **Covered Dependent Child(ren)**, the indicated percentage applies to loss of life only.]

[In no event will the amount be greater than **Your Principal Sum**.]]

[The **Principal Sum** for **Covered Dependents** will be [a choice of] the following amounts:

Spouse[/Domestic Partner]: [$50,000] [$75,000] [$100,000]

Dependent Child(ren): [$10,000] [$15,000] [$20,000] [$25,000]

[In no event will the amount be greater than **Your Principal Sum**.]]

[Principal Sum Reduction

[At age [70], [for **You** only,] the **Principal Sum** will be reduced based on [**Your**] [the **Insured Person's**] previous **Principal Sum** per the following schedule:

Age at Date of Loss	**Percent of Principal Sum**
[70-74]	[65%]
[75-79]	[45%]
[80-84]	[30%]
[85 & Over]	[15%]]

[Aggregate Limit of Liability

[The **Aggregate Limit of Liability** per [air travel] **Covered Accident** is [$0.00].]

[The **Aggregate Limit of Liability** per [on-premises Felonious Assault Coverage,][On-Premises Terrorism Coverage,][War Risk Coverage,][on-premises Bomb Scare/Explosion Coverage] **Covered Accident** [combined] is [$0.00].]]

[**Escalator Clause**

We will increase **Your Accidental Death Benefit** at an amount equal to [2%] of **Your Principal Sum** for each year **You** remain continuously covered under the **Policy** for a maximum of [five (5)] years. [If **You** selected a **Plan** covering **Your Dependent(s)**, the **Principal Sum** for **Your Covered Dependent(s)** will be calculated from **Your** original **Principal Sum**, and therefore this increase does not affect **Your Covered Dependent's Accidental Death Benefit(s)**.]

The first increase will take effect one year from the **Policy** anniversary date that is equal to or later than the date **You became** eligible for benefits under the **Policy**. Future increases will take effect on subsequent **Policy** anniversary dates. The increase will be based on **Your Principal Sum** on the day immediately prior to the **Policy** anniversary date.]

B. Accidental Death Benefit

This benefit applies to [all Classes of **Primary Insured Persons** [and their **Covered Dependents**]] **[**Class 1 [and their **Covered Dependents**]] [Classes 2 and 3 [and their **Covered Dependents**]].

C. [Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Benefit

This benefit applies to [all Classes of **Primary Insured Persons** [and their **Covered Dependents**]] **[**Class 1 [and their **Covered Dependents**]] [Classes 2 and 3 [and their **Covered Dependents**]]

D. [Coma Benefit]

This benefit applies to [all Classes of **Primary Insured Persons** [and their **Covered Dependents**]] **[**Class 1 [and their **Covered Dependents**]] [Classes 2 and 3 [and their **Covered Dependents**]]

E. [Additional Benefits

[All Classes [including their **Covered Dependents**]:]	[Seat Belt Benefit]
	[Rehabilitation Benefit]
	[Accident Weekly Indemnity Benefit]
[Class 1 [and their **Covered Dependents**]:]	[Accident Medical Benefit]]

[ENDORSEMENTS

The following Endorsements have been attached to and are included in the **Policy**:

[Administrative Change Endorsement] [Endorsement No. [1]] [XX 12345] [for: Class 2]]

SECTION III – HAZARDS

[24 HOUR ACCIDENT PROTECTION, BUSINESS AND PLEASURE
[EXCLUDING] [INCLUDING] CORPORATE OWNED OR LEASED AIRCRAFT,
[AND SUBSTITUTE AIRCRAFT,]
[PASSENGER ONLY] [PASSENGER AND CREW]

The **Policy** insures against the following **Hazards**:

A **Covered Injury** sustained by [**You**] [an **Insured Person**] [anywhere in the world], subject to the terms, conditions, exclusions and limitations under the **Policy**.

[Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a trip, while [**You** are] [the **Insured Person** is] [a passenger,] [pilot, operator, member of the crew or cabin attendant,] riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
   - **a.** medical certificate; and
   - **b.** pilot certificate with a proper rating to pilot such aircraft.
2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.]

[Hazard Exclusions:

Coverage is not provided:

1. [If [**You** are**]** [the **Insured Person** is] the pilot, operator, member of the crew or cabin attendant of any aircraft [except those aircraft specified below].]
2. [Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   - **a. [**any aircraft other than those expressly stated in this **Hazard**;]

b. [any aircraft [**Owned** or] [**Controlled** by, or] [**Under lease** to] the **Policyholder** [except the following aircraft, [including **Substitute Aircraft**]:

[Description of Aircraft]

provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least [1,000] hours as a pilot of which at least [500] hours were logged in this or the same class of aircraft.]]

c. [any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured Person** [or a member of an **Insured Person's** [family or] household];]

d. [any aircraft operated by [the **Policyholder** [except those indicated in b. above, [including **Substitute Aircraft**]]or] one of the **Policyholder's** employees [including members of an employee's [family or] household];]

e. [any aircraft engaged in a **Specialized Aviation Activity**;**]**

f. [any conveyance [except aircraft] used [for tests or experimental purposes, [or]] [in a race or speed test].]]]

[**Hazard Definitions:**

[**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:

1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;

2. is the same class of aircraft as the specified aircraft; and

3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.]]

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII Limitations and Section VIII General Exclusions.

H1-XX]

[24 HOUR ACCIDENT PROTECTION WHILE ON BUSINESS TRIP,
[EXCLUDING] [INCLUDING] CORPORATE OWNED OR LEASED AIRCRAFT,
[AND SUBSTITUTE AIRCRAFT,]
[PASSENGER ONLY] [PASSENGER AND CREW]

The Policy insures against the following **Hazards**:

A **Covered Injury** sustained by **You [**anywhere in the world] while on the **Business of the Policyholder** [during a business trip] [and during a **Bona Fide Trip**], subject to the terms, conditions, limitations and exclusions under the **Policy**.

Coverage, subject to limitations and exclusions, is provided between:

1. the later of the time **You** leave the place where **You** normally work or live; and

2. the earlier of the time **You** return to the place where **You** normally work or live.

[Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a trip, while **You** are [a passenger,] [pilot, operator, member of the crew or cabin attendant,] riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:

a. medical certificate; and

b. pilot certificate with a proper rating to pilot such aircraft.

2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.]

[Hazard Exclusions:

Coverage is not provided:

1. [If **You** are the pilot, operator, member of the crew or cabin attendant of any aircraft [except those aircraft specified below].]
2. [For an assignment by the **Policyholder** or relocation that exceeds [sixty (60)] days in duration. Note: If an assignment exceeds [sixty (60)] days in duration, the location of the assignment will be considered the place of permanent assignment, and **You** will then have **Coverage** when traveling elsewhere on the **Business of the Policyholder**.]
3. [Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   a. **[**any aircraft other than those expressly stated in this **Hazard**;]
   b. [any aircraft [**Owned** or] [**Controlled** by, or] [**Under lease** to] the **Policyholder** [except the following aircraft, [including **Substitute Aircraft**]:

      [Description of Aircraft]

      provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least [1,000] hours as a pilot of which at least [500] hours were logged in this or the same class of aircraft.]]
   c. [any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured Person** [or a member of an **Insured Person's** [family or] household];]
   d. [any aircraft operated by [the **Policyholder** [except those indicated in b. above, [including **Substitute Aircraft**]]or] one of the **Policyholder's** employees [including members of an employee's [family or] household];]
   e. [any aircraft engaged in a **Specialized Aviation Activity**;]
   f. [any conveyance [except aircraft] used [for tests or experimental purposes, [or]] [in a race or speed test].]]]

Hazard Definitions:

- **Business of the Policyholder** means an assignment by or at the direction of the **Policyholder** to further the business of the **Policyholder**. It does not include an **Accident** occurring during usual travel to and from work; bona fide leaves of absence or vacation [; or **Personal Deviations/Side Trips** of a personal nature]. [It does not include employees who are hired to operate a truck.] [It does include **Personal Deviations/Side Trips** of a personal nature.]
- [**Bona Fide Trip** means a trip that requires **You** to travel outside the limits of the city or municipality where **You** normally work.]
- [**Personal Deviations/Side Trips** means non-business activities and/or travel of a personal nature, undertaken while on the **Business of the Policyholder**, but unrelated to furthering the **Business of the Policyholder** that: 1) is incidental to the business trip; 2) would not have been taken if not for the business trip; [and] 3) is taken during the course of the business trip[.] [; and 4) is limited to [72 hours]].]
- [**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:
  1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
  2. is the same class of aircraft as the specified aircraft; and
  3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.]

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII Limitations and Section VIII General Exclusions.

H2-XX]

[24 HOUR ACCIDENT PROTECTION WHILE [ON A SPECIFIED TRIP][ATTENDING A SPECIFIED EVENT],
[EXCLUDING] [INCLUDING] CORPORATE OWNED OR LEASED AIRCRAFT,
[AND SUBSTITUTE AIRCRAFT,]
[PASSENGER ONLY] [PASSENGER AND CREW]

The **Policy** insures against the following **Hazards**:

A **Covered Injury** sustained by **You** during a specified [trip] [event], subject to the terms, conditions, limitations and exclusions under the **Policy**, during a specified [trip] [event] to:

[insert destination/description of trip]

Coverage, subject to limitations and exclusions, is provided between

[**1.** the later of the time **You** leave the place where **You** normally work or live; and

2. the earlier of the time **You** return to the place where **You** normally work or live.]

[**1.** the time **You** arrive at the exact location of the specified [trip] [event] ; and

2. the time **You** leave the exact location of the specified [trip] [event].]

[Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during the [trip] [event], while **You** are [a passenger,] [pilot, operator, member of the crew or cabin attendant,] riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
   a. medical certificate; and
   b. pilot certificate with a proper rating to pilot such aircraft.

2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.]

[Hazard Exclusions:

Coverage is not provided:

1. [If **You** are the pilot, operator, member of the crew or cabin attendant of any aircraft [except those aircraft specified below].]

2. [For **Your** travel or activities, which deviate from the requirements for [making the specified trip] [attending the specified event], or travel that is an extension of the specified [trip] [event]. [This includes [**Personal Deviations/Side Trips** of a personal nature.] [This does not include **Personal Deviations/Side Trips** of a personal nature.]]

3. [Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   a. [any aircraft other than those expressly stated in this **Hazard**;]
   b. [any aircraft [**Owned** or] [**Controlled** by, or] [**Under lease** to] the **Policyholder** [except the following aircraft, [including **Substitute Aircraft**]:

   [Description of Aircraft]

   provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least [1,000] hours as a pilot of which at least [500] hours were logged in this or the same class of aircraft.]]
   c. [any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured Person** [or a member of an [family or]household];]
   d. [any aircraft operated by [the **Policyholder** [except those indicated in b. above, [including **Substitute Aircraft**]]or] one of the **Policyholder's** employees [including members of an employee's [family or] household];]
   e. [any aircraft engaged in a **Specialized Aviation Activity**;]

f. [any conveyance [except aircraft] used [for tests or experimental purposes, [or]] [in a race or speed test].]]]

[**Hazard Definitions:**

- [**Personal Deviations/Side Trips** means non-business activities and/or travel of a personal nature, undertaken while [on the specified trip] [attending the specified event], but unrelated to the specified [trip] [event] that: 1) is incidental to the specified [trip][event]; 2) would not have been taken if not for the specified [trip][event]; [and] 3) is taken during the course of the specified [trip][event][.] [; and 4) is limited to [72 hours]].]
- [**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:
  1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
  2. is the same class of aircraft as the specified aircraft; and
  3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.]]

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII Limitations and Section VIII General Exclusions.

H3-XX]

[FULL OCCUPATIONAL COVERAGE, [EXCLUDING] [INCLUDING] CORPORATE OWNED OR LEASED AIRCRAFT, [AND SUBSTITUTE AIRCRAFT,] [PASSENGER ONLY] [PASSENGER AND CREW]

The **Policy** insures against the following **Hazards**:

A **Covered Injury** sustained by **You [**anywhere in the world] while on or off the premises of the **Policyholder** performing the usual and customary duties of **Your** regular occupation, or while on the **Business of the Policyholder** during a **Bona Fide Trip**, subject to the terms, conditions, limitations and exclusions under the **Policy**.

[Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a **Bona Fide Trip**, while **You** are [a passenger,] [pilot, operator, member of the crew or cabin attendant,] riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid, normal, transport or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. The aircraft must be operated by a pilot with a current and valid:
   a. medical certificate; and
   b. pilot certificate with a proper rating to pilot such aircraft.
2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.]

[Hazard Exclusions:

Coverage is not provided:

1. [If **You** are the pilot, operator, member of the crew or cabin attendant of any aircraft [except those aircraft specified below].]
2. [Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   a. [any aircraft other than those expressly stated in this **Hazard**;]
   b. [any aircraft [**Owned** or] [**Controlled** by, or] [**Under lease** to] the **Policyholder** [except the following aircraft, [including **Substitute Aircraft**]:

   [Description of Aircraft]

   provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has

logged at least [1,000] hours as a pilot of which at least [1,000] hours were logged in this or the same class of aircraft.]]

c. **[**any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured Person** [or a member of an **Insured Person's** [family or] household];]

d. [any aircraft operated by [the **Policyholder** [except those indicated in b. above, [including **Substitute Aircraft**]]or] one of the Policyholder's employees [including members of an employee's [family or] household];]

e. [any aircraft engaged in a **Specialized Aviation Activity**;**]**

f. [any conveyance [except aircraft] used [for tests or experimental purposes, [or]] [in a race or speed test].]]]

Hazard Definitions:

- **Bona Fide Trip** means a trip that begins when **You** leave the place where **You** normally work or live (whichever last occurs) to go on the trip. It ends when **You** return from the trip to the place where **You** normally work or live (whichever occurs first).
- **Business of the Policyholder** means while on assignment by or at the direction of the **Policyholder** to further the **Business of the Policyholder**. It does not include an **Injury** sustained during:
  1. usual travel to and from work;
  2. leaves of absence or vacations[.] [; or
  3. [**Personal Deviations/Side Trips** of a personal nature, during a **Bona Fide Trip**, that are not at the direction of and in furtherance of the economic interest of the **Policyholder**.]

  [It does not include employees who are hired to operate a truck.]

  [It does include **Personal Deviations/Side Trips** of a personal nature.]
- **[Personal Deviations/Side Trips** means non-business activities and/or travel of a personal nature, undertaken while on the **Bona Fide Trip**, but unrelated to the **Bona Fide Trip** that: 1) is incidental to the **Bona Fide Trip**; 2) would not have been taken if not for the **Bona Fide Trip**; [and] 3) is taken during the course of the **Bona Fide Trip**[.] [; and 4) is limited to [72 hours]].]
- [**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:
  1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
  2. is the same class of aircraft as the specified aircraft; and
  3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.]

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII Limitations and Section VIII General Exclusions.
H4-XX]

SECTION IV – ADDITIONAL COVERAGES

[**SPECIFIED PILOT COVERAGE**

The **Hazard** Exclusion in [**24 Hour Accident Protection**, **Business and Pleasure** [**Excluding**][**Including**] **Corporate Owned or Leased Aircraft**, [**and Substitute Aircraft**,] [**Passenger Only**] [**Passenger and Crew**]] [**24 Hour Accident Protection While on Business Trip**, [**Excluding**] [**Including**] **Corporate Owned or Leased Aircraft**, [**and Substitute Aircraft**,][**Passenger Only**] [**Passenger and Crew**]] [**24 Hour Accident Protection While [on a Specified Trip**] [**Attending a Specified Event**], [**Excluding**] [**Including**] **Corporate Owned or Leased Aircraft** [**and Substitute Aircraft**,] [**Passenger Only**] [**Passenger and Crew**]] [**Full Occupational Coverage**, [**Excluding**] [**Including**] **Corporate Owned or Leased Aircraft**, [**and Substitute Aircraft**,] [**Passenger Only**] [**Passenger and Crew**]] stating that **"Coverage** is not provided: **1.** if [**You** are][the **Insured Person** is] the pilot, operator, member of the crew or cabin attendant of any aircraft." is modified to provide **Coverage** for the following named pilot(s) only:

[**Pilot Name**(**s**)]

while piloting the following aircraft:

[**Aircraft Description(s)**]

provided such aircraft has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor, and the above named pilot(s) has a current and valid medical certificate and pilot certificate with a proper rating to fly such aircraft.

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C1-XX]

[**BOMB SCARE/EXPLOSION COVERAGE**

Coverage is extended to include a **Covered Injury** caused by, or resulting from, a **Bomb Scare**, **Bomb Search**, **Bomb Explosion** [or **Fire Drill**] occurring on the premises of the **Policyholder**, subject to the following definitions:

- **Bomb** means any real or imitative explosive device placed with intent to cause injury, damage or scare.
- **Scare** means any real or false report of the presence of a **Bomb** on the premises of the **Policyholder**.
- **Search** means any organized search for a reported **Bomb**.
- **Explosion** means any explosion of a **Bomb** on the **Policyholder's** premises whether or not the presence of a **Bomb** was reported in advance.
- [**Fire Drill** means while participating in a **Fire Drill** conducted by the **Policyholder** for the purpose of emergency preparedness.]

[For purposes of on-premises **Bomb Scare/Explosion Coverage**, [as well as [[on-premises] Felonious Assault Coverage,][On-Premises Terrorism Coverage,][War Risk Coverage,]] the **Aggregate Limit of Liability** per **Covered Accident** [combined] is [$0.00].]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C2-XX]

[**COMMUTATION COVERAGE**

Coverage is extended to include a **Covered Injury** sustained by **You** while commuting directly to or from **Your** home and place of regular employment. This **Coverage** begins when **You** leave **Your** home or place of work. This **Coverage** ends when **You** arrive at **Your** home or place of work.

Except for events beyond **Your** control, excluded **Injuries** are those arising out of or in the course of any deviation from **Your** normal route for personal reasons.

[This **Coverage** will not be extended if **You** are the operator of a private passenger automobile at the time **You** incur such **Covered Injury**, and **You** are either:

1. under the influence of alcohol;
   - **a.** **You** will be conclusively presumed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   - **b.** An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of **Your** intoxication. Or,
2. under the influence of

   [a [poison,] [fume,] [noxious chemical substance]that was deliberately ingested][;][or][a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.]]

   [a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions.]]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C3-XX]

EXPOSURE AND DISAPPEARANCE COVERAGE

If [**You** are] [an **Insured Person** is] exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which [**You** are] [an **Insured Person** is] riding disappears, is wrecked, or sinks, and [**You** are] [the **Insured Person** is] not found within [365] days of the event, **We** will presume that [**You]** [the **Insured Person**] lost [**Your] [**his or her] life as a result of **Injury**. If travel in such conveyance was covered under the terms of the **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that [**You**] [the **Insured Person**] survived the event.

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C4-XX

[**EXTRA-ORDINARY COMMUTATION COVERAGE**

Coverage is extended to include a **Covered Injury** sustained by **You** while commuting directly between **Your** home, and place of regular employment. This can be by car or other conveyance. For this **Coverage** to take effect there must be a stop in service due to a strike or major breakdown of one or more public transit systems **You** regularly use.

This **Coverage** begins when **You** leave **Your** home or place of work. This **Coverage** ends when **You** arrive at **Your** home or place of work. Except for events beyond **Your** control, no losses will be covered if **You** deviate from **Your** normal route.

[This **Coverage** will not be extended if **You** are the operator of a private passenger automobile at the time **You** incur such **Covered Injury**, and **You** are either:

1. under the influence of alcohol;
   - **a.** **You** will be conclusively presumed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   - **b.** An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of **Your** intoxication. Or,

2. under the influence of

[a [poison,] [fume,] [noxious chemical substance] that was deliberately ingested][;][or][a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.]]

[a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions.]]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C5-XX]

[**FAMILY TRAVELING WITH EMPLOYEE ON BUSINESS AND/OR RELOCATION TRIPS COVERAGE**

Your Spouse [/**Domestic Partner**] and/or **Dependent Child(ren)** will also be considered a **Primary Insured Person** when they are traveling on a business and/or relocation trip with **You** that is approved by and at the expense of the **Policyholder**. Their coverage will be limited to the **Accidental Death Benefit** [and the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit**] as stated in the **Policy**, when the eligibility for such **Benefit** results from the **Hazards** covered by the **Policy**.

This **Coverage** for **Your Spouse** [/**Domestic Partner**] and/or **Dependent Child(ren)** ends upon arrival at the destination of the **Policyholder's** last reimbursed trip.

The **Principal Sum** for **Your Spouse** [/**Domestic Partner**] and each **Dependent Child** will be as follows:

Spouse [/**Domestic Partner**]:	$[50,000]
Dependent Child(ren):	$[25,000]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C6-XX]

[**FELONIOUS ASSAULT COVERAGE**

Coverage is extended to **You** if **You** sustain a **Covered Injury** as defined under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, as a direct result of a violent or criminal act committed by someone other than **You**, [a **Fellow Employee] [**or a member of **Your Family** or **Household**,] provided:

1. [the **Injury** is incurred in connection with or related to the **Policyholder's** business; and]
2. the **Injury** occurs on the **Policyholder's** premises.

[For purposes of this **Coverage**:

[Fellow Employee means a person employed by the same employer as **You** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than [forty-five (45) days] prior to the date on which the defined violent crime/felonious assault was committed.]

[Family means **Your** parent, stepparent, **Spouse** or former **Spouse**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.]

[Household means a person who maintains residence at the same address as **You**.]

[This **Coverage** applies [only to the crimes or attempted crimes of robbery, theft, holdup, kidnapping.][to any willful or unlawful use of force in connection with the commission of or the attempt to commit a crime including, but not limited to, [robbery,][theft,][kidnapping,][hostage-taking,][assault,][battery,][sniping,][murder,][manslaughter,][riot,] or [insurrection]) that: 1.) results in a covered injury; and 2.) is a felony in the jurisdiction in which it occurs.]]

[For purposes of [on-premises] **Felonious Assault Coverage**, [as well as [on-premises Bomb Scare/Explosion Coverage,] [On-Premises Terrorism Coverage,][War Risk Coverage,]] the **Aggregate Limit of Liability** per **Covered Accident** [combined] is [$0.00].]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C7-XX]

[**HIJACKING** or **SKYJACKING COVERAGE**

The exclusion for war or any acts of war whether declared or undeclared as found in Section VIII General Exclusions of this **Certificate** is modified, and **Covered Injuries** directly resulting from a **Hijacking** or **Skyjacking** or any attempt at any **Hijacking** or **Skyjacking** are covered under the **Policy**.

Hijacking or **Skyjacking** means the unlawful seizure or wrongful exercise of control of an aircraft [or conveyance] or the crew thereof, in which [**You** are] [the **Insured Person** is] traveling as a passenger.

This **Coverage** will continue beyond the actual **Hijacking** or **Skyjacking** while [**You** are] [the **Insured Person** is]:

1. subject to the control of the person(s) making the **Hijacking** or **Skyjacking**; and
2. traveling directly to [**Your**] [the **Insured Person's**] home or original destination.

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C8-XX]

[**ON-PREMISES TERRORISM COVERAGE**

Coverage is extended to **You** if **You** sustain a **Covered Injury** as defined under the **Accidental Death Benefit [**or **Accidental Dismemberment** [**and Covered Loss of Use**][**and Plegia**] **Benefit]** as a direct result of an **Act of Terrorism** while **You** are performing the **Policyholder's** business on the **Policyholder's** premises.

[The benefit for this **On-Premises Terrorism Coverage** will be [15%] of the applicable **Principal Sum** subject to a maximum of [$100,000].]

Act of Terrorism means any intentionally violent or forceful act of any person(s), acting on behalf of an organization or group, with the purpose of creating political turmoil or overthrowing any government.

[For purposes of **On-Premises Terrorism Coverage**, [as well as [[on-premises] Felonious Assault Coverage,] [on-premises Bomb Scare/Explosion Coverage,] [War Risk Coverage,]] the **Aggregate Limit of Liability** per **Covered Accident** [combined] is [$0.00].]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C9-XX]

[**RESERVE CORPS/NATIONAL GUARD UNIT COVERAGE**

If **You** sustain an **Injury**, resulting in a **Covered Loss**, as defined under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, while **You** are a member of an organized **Reserve Corps** or **National Guard Unit** and as such, **You** are:

1. attending any regularly scheduled or routine training of less than [sixty (60)] days, or **You** are enroute to or from such training;
2. attending a **Service School** or **You** are enroute to or from such **Service School**;
3. taking part in any authorized inactive duty training; or,
4. taking part as a unit member in a parade or exhibition authorized by official orders;

You will be eligible to receive the applicable **Principal Sum** for such **Covered Loss**.

[No benefit will be payable for any loss that occurs during active duty.]

For purposes of this **Coverage**, **Service School** means one operated by, or on behalf of, the United States of America or Canada.

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C10-XX]

[**WAR RISK COVERAGE**

The exclusion for war or any acts of war, whether declared or undeclared, as found in Section VIII General Exclusions of this **Certificate** is modified, and **Covered Injuries** directly resulting from war or any acts of war, whether declared or undeclared, are covered under the **Policy**, provided the war or act of war causing the **Injury** does not occur within any of the states of the United States of America (including the District of Columbia) [[or **Your**] [or the **Insured Person**'**s**] country of [residence] [citizenship]] [or the list of countries as on file with the **Policyholder** and **Us**].

[For purposes of **War Risk Coverage** [as well as [on-premises Bomb Scare/Explosion Coverage,] [On-Premises Terrorism Coverage,] [[on-premises] Felonious Assault Coverage,]] the **Aggregate Limit of Liability** per **Covered Accident** [combined] is [$0.00].]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C11-XX]

SECTION V – BENEFITS

ACCIDENTAL DEATH BENEFIT

We will pay the applicable **Principal Sum**, if [**You** sustain] [an **Insured Person** sustains] a loss of life as a result of a **Covered Injury**, and the death occurs within [365] days of the **Covered Injury**.

This benefit is subject to the limitations in Section VII Limitations.

B1-XX

[**ACCIDENTAL DISMEMBERMENT** [**AND LOSS OF USE**] [**AND PLEGIA**] **BENEFIT**

We will pay the benefit amount shown below, if an **Injury** to [**You**] [or **Your Covered Spouse** [/**Domestic Partner**]] [an **Insured Person**] results in any of the following **Covered Losses**, provided the **Covered Loss** occurs within [365] days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person sustaining the **Covered Loss**.

Covered Loss of	**Benefit**
• Both Hands or Both Feet	[**Principal Sum**]

• One Hand and One Foot	[**Principal Sum**]
• One Hand or One Foot plus the loss of Sight of One Eye	[**Principal Sum**]
• Sight of Both Eyes	[**Principal Sum**]
• Speech and Hearing	[**Principal Sum**]
• Speech or Hearing	[50% of **Principal Sum**]
• One Hand; One Foot; or Sight of One Eye	[50% of **Principal Sum**]
• Thumb and Index Finger of the same Hand	[25% of **Principal Sum**]
• [Hearing in One Ear	[25% of **Principal Sum**]]

[A reduced benefit will be payable equal to [50%] of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after [365 days], the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.]

[**Covered Loss of Use** of	**Benefit**
• Four **Limbs**	[**Principal Sum**]
• Three **Limbs**	[75% of **Principal Sum**]
• Two **Limbs**	[66 2/3% of **Principal Sum**]
• One **Limb**	[50% of **Principal Sum**]]

[**Plegia**	**Benefit**
• Quadriplegia (total paralysis of all four **Limbs**)	[**Principal Sum**]
• [Triplegia (total paralysis of three **Limbs**)	[75% of **Principal Sum**]]
• Paraplegia (total paralysis of both lower **Limbs**)	[66 2/3% of **Principal Sum**]
• Hemiplegia (total paralysis of upper and lower **Limbs** on one side of the body)	[50% of **Principal Sum**]
• [Uniplegia (total paralysis of one **Limb**)	[25% of **Principal Sum**]]]

For purposes of this benefit:

- **Covered Loss** means:
  - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
  - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
  - **c.** Total and permanent loss of sight;
  - **d.** Total and permanent loss of speech;
  - **e.** Total and permanent loss of hearing.
- [**Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which [has continued for [12] consecutive months and] is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.]
- [**Plegia** must [continue for [twelve (12)] consecutive months and] be determined by **Our** competent medical authority to be a permanent, complete and irreversible paralysis of [two] or more **Limbs**. A **Limb** means an arm or a leg. Proof of total paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.]

This benefit is subject to the limitations in Section VII Limitations.

[B2-XX][B3-XX][B4-XX]]

[ACCIDENTAL DISMEMBERMENT [AND COVERED LOSS OF USE] [AND PLEGIA] BENEFIT FOR COVERED DEPENDENT CHILDREN

We will pay the benefit shown, if an **Injury** to **Your Covered Dependent Child(ren)** results in any of the following **Covered Losses**, provided the **Covered Loss** occurs within [365] days of the **Accident**:

Covered Loss of	**Percentage** of **Your Principal Sum**
• Both Hands or Both Feet	[50%] to a maximum of $[100,000]
• One Hand and One Foot	[50%] to a maximum of $[100,000]
• One Hand or One Foot plus the loss of Sight of One Eye	[50%] to a maximum of $[100,000]
• Sight of Both Eyes	[50%] to a maximum of $[100,000]
• Speech and Hearing	[50%] to a maximum of $[100,000]
• Speech or Hearing	[25%] to a maximum of $[50,000]
• One Hand; One Foot; or Sight of One Eye	[25%] to a maximum of $[50,000]
• Thumb and Index Finger of the same Hand	[12.5%] to a maximum of $[25,000]
• [Hearing in One Ear	[12.5%] to a maximum of $[25,000]]

[A reduced benefit will be payable equal to [50%] of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after [365 days], the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.]

[**Covered Loss of Use** of	**Percentage** of **Your Principal Sum**
• Four **Limbs**	[50%] to a maximum of $[100,000]
• Three **Limbs**	[37.5%] to a maximum of $[75,000]
• Two **Limbs**	[33%] to a maximum of $[66,000]
• One **Limb**	[25%] to a maximum of $[50,000]]

[**Plegia**	**Percentage** of **Your Principal Sum**
• Quadriplegia (total paralysis of all four **Limbs**)	[50%] to a maximum of $[100,000]
• [Triplegia (total paralysis of three **Limbs**)	[37.5%] to a maximum of $[75,000]]
• Paraplegia (total paralysis of both lower **Limbs**)	[33%] to a maximum of $[66,000]
• Hemiplegia (total paralysis of upper and lower **Limbs** on one side of the body)	[25%] to a maximum of $[50, 000]
• [Uniplegia (total paralysis of one **Limb**)	[12.5%] to a maximum of $[25,000]]]

For purposes of this **Benefit**:

- **Covered Loss** means:
  - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
  - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
  - **c.** Total and permanent loss of sight;
  - **d.** Total and permanent loss of speech;
  - **e.** Total and permanent loss of hearing.
- [**Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which [has continued for [twelve (12)] consecutive months and] is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.]
- [**Plegia** must [continue for [twelve (12)] consecutive months and] be determined by **Our** competent medical authority to be a permanent, complete and irreversible paralysis of [two (2)] or more **Limbs**. A **Limb** means an arm or a leg. Proof of total paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.]

This benefit is subject to the limitations in Section VII Limitations.

[B5-XX][B6-XX][B7-XX]]

[ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT

We will pay the benefit **s**hown below, if an **Injury** to [**You]** [an **Insured Person**] results in any of the following **Covered Losses**, provided **t**he **Covered Loss** occurs within [365] days of the **Accident**.

The benefit amounts are based on [**Your**] [the **Insured Person's**] **Principal Sum**.

Covered Loss of	**Benefit**
1. Two **Limbs**	[**Principal Sum**]
2. Both hands or all fingers and thumbs of both hands	[**Principal Sum**]
3. Sight of both eyes	[**Principal Sum**]
4. Paralysis of all **Limbs**	[**Principal Sum**]
5. One arm at shoulder	[60% of **Principal Sum**]
6. One arm between shoulder and elbow	[50% of **Principal Sum**]
7. One arm at elbow	[47.5% of **Principal Sum**]
8. One arm between elbow and wrist	[45% of **Principal Sum**]
9. One hand at wrist	[42.5% of **Principal Sum**]
10. Four fingers and thumb of one hand	[42.5% of **Principal Sum**]
11. Four fingers of one hand	[35% of **Principal Sum**]
12. Phalanges of one thumb	[20% of **Principal Sum**]
13. One phalanx of one thumb	[10% of **Principal Sum**]
14. Three phalanges of one index finger	[10% of **Principal Sum**]
15. Two phalanges of one index finger	[8% of **Principal Sum**]
16. One phalanx of one index finger	[4% of **Principal Sum**]
17. Three phalanges of one middle finger	[6% of **Principal Sum**]
18. Two phalanges of one middle finger	[4% of **Principal Sum**]
19. One phalanx of one middle finger	[2% of **Principal Sum**]
20. Three phalanges of one ring finger	[5% of **Principal Sum**]
21. Two phalanges of one ring finger	[4% of **Principal Sum**]
22. One phalanx of one ring finger	[2% of **Principal Sum**]
23. Three phalanges of one little finger	[4% of **Principal Sum**]
24. Two phalanges of one little finger	[3% of **Principal Sum**]
25. One phalanx of one little finger	[2% of **Principal Sum**]
26. First or second metacarpal	[3% of **Principal Sum** each]
27. Third fourth or fifth metacarpal	[2% of **Principal Sum** each]
28. One leg at hip	[50% of **Principal Sum**]
29. One leg between hip and knee	[50% of **Principal Sum**]
30. One leg below the knee	[40% of **Principal Sum**]
31. All toes of one foot	[15% of **Principal Sum**]
32. Both phalanges of one great toe	[5% of **Principal Sum**]
33. One phalanx of one great toe	[2% of **Principal Sum**]
34. Toes other than great toe	[1% of **Principal Sum** each]
35. One eye by removal	[30% of **Principal Sum**]
36. All sight in one eye	[25% of **Principal Sum**]
37. All sight in one eye except for perception of light	[25% of **Principal Sum**]
38. All the lens of one eye	[20% of **Principal Sum**]
39. All hearing in both ears	[40% of **Principal Sum**]
40. All hearing in one ear	[7% of **Principal Sum**]

[A reduced benefit will be payable equal to [50%] of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after

[365] days, the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.]

For purposes of this benefit, **Covered Loss** means the actual severance of any member or the total and permanent **Loss of Use** of such member. **Covered Loss of Use** means total paralysis of the member, which is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.

[The benefit for:

1. any and all phalanges of the fingers and thumb of one hand in the aggregate will not exceed the benefit for the **Covered Loss** of four fingers of one hand; and
2. any or all of the phalanges of the fingers of one hand in the aggregate will not exceed the compensation for the **Covered Loss** of four fingers of one hand.]

This benefit is subject to the limitations in Section VII Limitations.

B8-XX]

[**COMA BENEFIT**

We will pay a **Coma Benefit**, if [**You** sustain] [an **Insured Person** sustains] an **Injury** within [365] days of an **Accident**, and such **Injury** causes [**You**] [the **Insured Person**] to be in a **Coma** for at least [thirty-one (31)] consecutive days.

[The **Coma Benefit** is equal to [1%] of [**Your**] [the **Insured Person's**] **Principal Sum**, and will be paid each month [**You** remain] [the **Insured Person** remains] in a **Coma** following the initial [thirty-one (31)] day period. The **Coma Benefit** will end on the earliest of the following:

1. [**You** are] [the **Insured Person** is] no longer in a **Coma** which directly resulted from the **Injury**;
2. [**You** have] [the **Insured Person** has] received a **Coma Benefit** for [100] months.]

[The **Coma Benefit** will be payable at [1%] of [**Your**] [the **Insured Person's**] **Principal Sum** per month for the first [11] months [**You** remain] [the **Insured Person** remains] in a **Coma**, following the initial [thirty-one (31)] day period. At the end of the [11] months of payment, if [**You** remain] [the **Insured Person** remains] in a **Coma**, **We** will pay a lump sum benefit equal to the **Principal Sum** payable under the **Accidental Death Benefit** less the amount of the [11] months of benefit already received.]

Brief periods of consciousness of no more than [one (1) day] in duration will not effect [**Your**] [the **Insured Person's**] eligibility for, or continuation of, benefits.

Coma will be determined by **Our** duly licensed **Physician**.

This benefit is subject to the limitations in Section VII Limitations.

B9-XX]

[**HIV OCCUPATIONAL ACCIDENT BENEFIT**

We will pay an **HIV Benefit**, if **You** sustain an **Injury** resulting in a **Covered Loss** while performing **Your** job related duties, which causes **You** to acquire and test positive within [365 days] of such **Accident** for Human Immunodeficiency Virus (HIV) and/or AIDS and related complex (ARC). Such **HIV Benefit** will be equal to [20%] of **Your Principal Sum** at the date of the **Accident**, but will not exceed [$50,000]. The **HIV Benefit** will be paid in [twenty-four (24)] equal monthly installments.

In order to receive the **HIV Benefit**, **You** must:

1. submit a Workers' Compensation injury report to **Your** employer within forty-eight (48) hours of the **Accident**. If **Your** employer does not maintain Workers' Compensation insurance, **You** must complete an **Accident** report on a form that **We** will provide. The completed **Accident** report must be approved by the **Policyholder** within forty-eight (48) hours of the **Accident** and must be submitted to **Us** within five (5) days of the **Accident**; and
2. submit to a blood test for HIV and/or AIDS and/or related complex (ARC) within forty-eight (48) hours of the **Accident**, which is administered by a duly licensed medical doctor or registered nurse. The blood test results must be sent directly to **Us**.

If the initial test is negative, and **You** subsequently test positive for HIV, AIDS or ARC within [365 days] of the **Accident**, **We** will begin monthly payments on the first of the month following the settlement of the claim.

This benefit is subject to the limitations in Section VII Limitations.

B10-XX]

[**IN-HOSPITAL INDEMNITY BENEFIT**

We will pay:

1. a monthly benefit of [1%] of [**Your**] [the **Insured Person's**] **Principal Sum** to a maximum of [$1,000]; or

2. for periods of less than one (1) month, one thirtieth of the amount calculated in number 1 above, for each complete day of confinement,

if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that requires [**You] [**him or her] to be confined in a **Hospital** for more than [seven (7)] consecutive days.

The initial **Hospital** confinement must begin within [ninety (90)] days of the **Injury** for **[You**] [the **Insured Person**] to be eligible for this benefit.

This benefit will be paid for a maximum of [twelve (12)] months for any **Covered Injury**.

Successive periods of **Hospital** confinement arising out of the same **Injury** will be considered one confinement only if they are separated by a period of less than three (3) months.

The term **Hospital** means a health care facility that meets all of the following requirements:

1. holds a license as a hospital, if required;

2. operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;

3. provides twenty-four (24) hour a day nursing service by registered nurses;

4. has a staff of one or more licensed **Physicians** available at all times;

5. has facilities for diagnosis, and major medical surgical facilities; and

6. is not primarily a clinic, nursing, rest or convalescent home or similar establishment, nor is not, other than incidentally, a substance abuse center or halfway house

This benefit is subject to the limitations in Section VII Limitations.

B11-XX]

[**PERMANENT AND TOTAL DISABILITY BENEFIT**

We will pay a **Permanent and Total Disability Benefit**, if **You** become **Permanently and Totally Disabled** as a result of a **Covered Injury**, provided that **You** become **Permanently and Totally Disabled** within [365] days of the **Injury**; and the **Permanent and Total Disability** continues for [twelve (12)] months. The benefit payable equals **Your Principal Sum** less any amount payable pursuant to the limitations in Section VII Limitations of this **Certificate**.

For purposes of this benefit, **Permanently and Totally Disabled** means that **You** are totally and continually disabled and cannot work, for any income, at any job that he or she is reasonably suited by education, training or experience to do. **Permanent and Total Disability** must be verified by a competent medical authority, and must be expected to continue for the remainder of **Your** life.

[Eligibility for this benefit ends at age [seventy (70)].]

B12-XX]

[PERMANENT AND TOTAL DISABILITY BENEFIT

We will pay a **Permanent and Total Disability Benefit**, if **You** become **Permanently and Totally Disabled** as a result of a **Covered Injury**, provided that **You** become **Permanently and Totally Disabled** within [365] days of the **Injury**; and the **Permanent and Total Disability** continues for [twelve (12)] months.

The monthly amount payable under this benefit will be equal to [1%] of **Your Principal Sum**. These payments will cease at the earlier of the time that:

1. **We** make [100] payments under this provision;

2. **You** are no longer **Permanently and Totally Disabled**;

3. **You** die.

For purposes of this benefit, **Permanently and Totally Disabled** means that **You** are totally and continually disabled and cannot work, for any income, at any job that **You** are reasonably suited by education, training or experience to do. **Permanent and Total Disability** must be verified by a competent medical authority, and must be expected to continue for the remainder of **Your** life.

This benefit is subject to the limitations in Section VII Limitations.

[Eligibility for this benefit ends at age [seventy (70)].]

B13-XX]

SECTION VI – ADDITIONAL BENEFITS

[**ACCIDENT DENTAL EXPENSE BENEFIT**

We will pay an **Accident Dental Expense Benefit**, if [**You** sustain] [an **Insured Person** sustains] a **Covered Injury** which causes [**You]** [him or her] to require treatment for damage to **Sound Natural Teeth**. This benefit will not exceed the **Reasonable and Customary** expenses incurred for the **Medically Necessary** treatment, replacement, or diagnosis of such **Sound Natural Teeth**, provided:

1. the damage to the teeth occurs within [thirty (30)] days of the **Covered Injury**;

2. the expenses are actually incurred and paid within [twenty-six (26)] weeks of the **Covered Injury**; and

3. the services are performed by a licensed dentist or dental surgeon.

The maximum amount payable under this benefit is $[3,000] for any one **Covered Accident**.

We will not cover expenses under this additional benefit for:

1. any expenses covered by Workers' Compensation;

2. any expenses covered by Medicare;

3. any services of a Federal, Veteran's, State or Municipal hospital for which [**You** are] [an **Insured Person** is] not liable for payment;

4. expenses which are more than **Reasonable and Customary**;

5. cosmetic, plastic, or restorative dental treatment unless **Medically Necessary** for the treatment of the **Covered Injury**;

6. the replacement or repair of existing dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, or caps;

7. expenses which [**You** recover] [the **Insured Person** recovers] in a settlement or court judgment;

8. expenses which are covered under any other insurance of any kind;

9. expenses which [**You** are] [the **Insured Person** is] not legally obligated to pay; or

10. expenses that are not **Medically Necessary** for the treatment of the **Covered Injury**.

Medically Necessary means that the dental service or treatment:

1. is essential for the diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed; and

2. meets generally accepted standards of dental practice.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;

2. the degree of professional skill required; and

3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

AB1-XX]

[**ACCIDENT MEDICAL EXPENSE BENEFIT**

We will pay an **Accident Medical Expense Benefit**, if [**You** sustain] [an **Insured Person** sustains] a **Covered Injury**, which causes [**You]** [him or her] to incur medical expenses. This benefit will not exceed the **Reasonable and Customary** expenses incurred by [**You**][the **Insured Person**], in excess of the deductible of [$1,000.00] [and any other valid and collectible insurance], provided that:

1. the first treatment or service occurs within [thirty (30)] days of the **Covered Injury**;

2. the medical expenses are incurred within [365 days] of the **Covered Injury**; and

3. [**You** are] [the **Insured Person** is] under the care and treatment of a **Physician** other than [**Your]** [his or her] spouse, children or any other person who is related to [**You**] [him or her].

The maximum amount payable under this benefit is $[5,000] for any one **Covered Accident**.

We will not cover expenses under this additional benefit for:

1. any **Pre-existing Condition**, until [**You** have] [the **Insured Person** has] been continuously covered under the **Policy** for [twelve (12)] consecutive months;

2. any expenses which are covered by Workers' Compensation;

3. any expenses covered by Medicare;

4. any services of a Federal, Veteran's, State or Municipal hospital for which [**You** are] [an **Insured Person** is] not liable for payment;

5. expenses which are more than the **Reasonable and Customary**;

6. cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Covered Injury**;

7. expenses which [**You** recover] [the **Insured Person** recovers] in a settlement or court judgment;

8. expenses which are covered under any other insurance of any kind;

9. expenses which [**You** are] [the **Insured Person** is] not legally obligated to pay;

10. **Custodial Services**;

11. expenses that are not **Medically Necessary** for the treatment of the **Covered Injury**.

Custodial Services means any services that are not intended primarily to treat a specific **Injury**. **Custodial Services** include, but will not be limited to, services:

1. related to watching or protecting [**You**] [the **Insured Person**];

2. related to performing or assisting [**You**] [the **Insured Person**] in performing any activities of daily living such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered; and

3. that are not required to be performed by trained or skilled medical personnel.

Medically Necessary means that the medical service or treatment:

1. is essential for the diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed;

2. meets generally accepted standards of medical practice; and

3. is ordered by a **Physician** within the scope of his or her practice.

Pre-existing Condition means a condition for which [**You** have] [the **Insured Person** has] sought or received medical advice or treatment during the [twelve (12)] months immediately preceding [**Your**] [his or her] effective date of **Coverage** under the **Policy**.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;

2. the degree of professional skill required; and

3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

AB2-XX]

[**ACCIDENT WEEKLY INDEMNITY BENEFIT**

We will pay an **Accident Weekly Indemnity Benefit**, if **You** sustain a **Covered Injury**, which renders **You Totally Disabled**, provided:

1. the **Total Disability** occurs within [thirty (30)] days of the date of the **Injury**;
2. **You** have satisfied the **Benefit Waiting Period** of [seven (7)] days; and
3. **You** are being attended to by a duly licensed **Physician**, other than a family member.

Payments will begin on the first day after the benefit **Waiting Period** and will continue for as long as **You** are **Totally Disabled**, but will not exceed the **Benefit Period** of [fifty-two (52)] weeks. The amount of the payments will be equal to [75%] of **Your Base Weekly Earnings** [reduced by] [(1) Workers' Compensation Disability Benefit;] [(2) Social Security Disability Benefits, excluding any amounts for which **Your Dependents** may qualify because of **Your** disability;] [(3) Social Security Retirement Benefits;] [(4) Group Disability Benefits sponsored by the **Policyholder**;] [(5) the amount of any disability income benefits from any automobile or no-fault policy or insurance].

This **Accident Weekly Indemnity Benefit** will not exceed the **Weekly Indemnity Amount** of [$400.00].

Additional Definitions:

- **Base Weekly Earnings** is **Base Annual Earnings** divided by 52.
- **Benefit Period** means the time period, after the end of the benefit **Waiting Period**, that benefits are payable under this benefit subject to any other restrictions or limitations in the **Policy**.
- **Total Disability** (**Totally Disabled**) means that **You** are unable to perform all the substantial and material duties required by his or her regular occupation.
- **Benefit Waiting Period** means the number of consecutive days at the start of a period of continuous **Total Disability** for which **We** will not pay benefits.

AB3-XX]

[**ADDITIONAL DISMEMBERMENT BENEFIT FOR CHILDREN**

We will pay **You** a benefit that will be equal to an additional [100%] of the benefit amount provided by the **Accidental Dismemberment Benefit** that is payable under the **Accidental Dismemberment Benefit**, if **You** select a **Plan** covering **Your** eligible **Dependent Child(ren)**, and **Your Covered Dependent Child** sustains an **Injury** resulting in a **Covered Loss**.

AB4-XX]

[**AFTER SCHOOL CARE BENEFIT**

We will pay an additional benefit for After School Care, if **You** [select a **Plan** covering **Your Dependents** and **You [**or **Your Covered Spouse** [/**Domestic Partner**]]] sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to the individual who incurs the expense on behalf of each [**Covered**] **Dependent Child** if:

1. on the date of the **Accident**, the [**Covered**] **Dependent Child** was enrolled in After School Care, or enrolls in such After School Care within [ninety (90)] days from the date of **Covered Loss**; and
2. the [**Covered**] **Dependent Child** is under age [13].

The **After School Care Benefit** will be equal to the lesser of:

1. the actual cost of the After School Care;
2. [2%] of [**Your Principal Sum] [**the **Principal Sum** of the **Insured Person** who sustained the **Covered Loss]**; or
3. [$2,000].

[If both **You** and **Your Covered Spouse** [/**Domestic Partner**] sustain a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **After School Care Benefit** will be based on **Your Principal Sum**.]

The **After School Care Benefit** will be paid annually for up to [four (4)] consecutive years, if:

1. the [**Covered**] **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the [**Covered**] **Dependent Child** remains enrolled in After School Care.

The After School Care provider may not be a relative or family member and proof, acceptable to **Us** must be provided to establish eligibility for this benefit.

[The maximum amount payable for all eligible [**Covered**] **Dependent Children** under this benefit is [$8,000].]

AB5-XX]

[**CARJACKING BENEFIT**

We will pay an additional benefit equal to [10%] of the applicable **Principal Sum** to a maximum of [$10,000], if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, as a direct result of an **Accident** that occurs during a **Carjacking** of a private passenger automobile that [**You** were] [the **Insured Person** was] operating, getting into or out of, or riding in as a passenger.

Verification of the **Carjacking** must be made part of an official police report within [twenty-four (24)] hours of the **Carjacking** or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within [twenty-four (24)] hours or as soon as reasonably possible, and such verification must be provided to **Us**.

For purposes of this benefit, **Carjacking** means a person other than [**You**] [the **Insured Person**] taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

AB6-XX]

[**COBRA BENEFIT**

We will pay an additional benefit to continue medical insurance for **Your** surviving family members for a period of [one (1) year] from the date of the **Covered Loss**, if **You** [select a **Plan** covering **Your Dependents** and **You**] sustain an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, and **You** are covered under a medical plan sponsored by the **Policyholder**. The amount payable under this benefit will be the lesser of:

1. [5%] of **Your Principal Sum**;
2. [$5,000]; or
3. The actual cost to **Your** surviving family members to continue medical coverage for [one (1) year] under the plan sponsored by the **Policyholder**.

AB7-XX]

[**COMMON CARRIER BENEFIT**

We will pay an additional benefit equal to the lesser of [$50,000] or [50%] of [**Your**] [the **Insured Person's**] **Principal Sum**, if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, provided [**You** sustain][the **Insured Person** sustains] the **Injury** while a passenger riding in or on, boarding, or getting off a **Common Carrier**.

For purposes of this benefit, **Common Carrier** means:

1. any land or water conveyance licensed to carry persons for hire;
2. any civilian aircraft that holds a certificate of Public Convenience and Necessity, a license, or a similar permit for civilian scheduled air carriers issued by the country where the aircraft is registered.

AB8-XX]

[**COMMON DISASTER BENEFIT**

If **You** select a **Plan** covering **Your Dependents** and **You** and **Your Covered Spouse** [**/Domestic Partner**] are both eligible for **Accidental Death Benefits** as a result of **Covered Injuries** sustained in the same **Accident** [and within [ninety (90)] days of such **Accident**,] the **Principal Sum** that would have been payable because of **Your Covered Spouse's** [**/Domestic Partner's**] **Accidental Death Benefit** will be increased to equal that payable for **Your** loss, provided [:

1. **You** and **Your Covered Spouse**[**/Domestic Partner**] are survived by one or more **Covered Dependent Child(ren)**; and
2.]the combined benefits of **You** and **Your Covered Spouse** [**/Domestic Partner**] are not more than [$500,000].

AB9-XX]

[**CONTINUATION OF COVERAGE BENEFIT**

All **Coverages** under the **Policy** that were in force on the date of the indicated **Covered Loss**, with respect to **Insured Persons** other than **You**, will be continued automatically for [365 days] after the date of the **Covered Loss** at no additional cost, if **You** select a **Plan** covering **Your Dependents**, and **You** sustain an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**.

AB10-XX]

[**CRITICAL BURN BENEFIT**

An additional benefit will be payable equal to the lesser of [10%] of the applicable **Principal Sum** or [$10,000], if [**You** are] [an **Insured Person** is] critically burned as a result of a **Covered Accident**, provided all terms and conditions of the **Policy** are met and:

1. [**You** have][the **Insured Person** has] received [third] degree or higher burns over [25%] of [**Your]** [his or her] body; and
2. [**You** have][the **Insured Person** has] undergone reconstructive surgery to treat the burned areas of the body; and
3. the reconstructive surgery has taken place within [365 days] of the occurrence of the **Injury**.

This benefit will not be paid for a critical burn that results from voluntary self-exposure to the sun or to artificial tanning devices.

[If benefits are also payable under the **Reconstructive Surgery Benefit**, only one benefit will be paid, the largest benefit.]

AB11-XX]

[**DAY CARE BENEFIT**

We will pay an additional benefit for Day Care expenses, if **You** [select a **Plan** covering **Your Dependents** and **You [**or **Your Covered Spouse** [/**Domestic Partner**]]] sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to the individual who incurs the expense on behalf of each [**Covered**] **Dependent Child** if:

1. on the date of the **Accident**, the [**Covered**] **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of **Covered Loss**; and
2. the [**Covered**] **Dependent Child** is under age [13].

The **Day Care Benefit** will be equal to the lesser of:

1. the actual cost of the Day Care;
2. [3%] of [**Your Principal Sum]** [the **Principal Sum** of the **Insured Person** who sustained the **Covered Loss]**; or
3. [$3,000].

[If both **You** and **Your Covered Spouse** [/**Domestic Partner**] sustain a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **Day Care Benefit** will be based on **Your Principal Sum**.]

The **Day Care Benefit** will be paid annually for up to [four (4)] consecutive years, if:

1. the [**Covered**] **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the [**Covered**] **Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

An **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

[The maximum amount payable for all eligible [**Covered] Dependent Children** under this benefit is [$12,000].]

AB12-XX]

[**FELONIOUS ASSAULT BENEFIT**

We will pay an additional benefit equal to the lesser of [10%] of **Your Principal Sum** or [$30,000], if **You** sustain an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]** as a result of a violent or criminal act committed by someone other than **You**, [a **Fellow Employee**,**] [**or a member of **Your Family** or **Household**,] provided:

1. the **Injury** is incurred in connection with the **Policyholder's** normal business whether on or off the **Policyholder's** premises[; and
2. the crime directly involves the **Policyholder's** funds or assets].

For purposes of this benefit:

[Fellow Employee means a person employed by the same employer as **You** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than [forty-five (45)] days prior to the date on which the defined violent crime/felonious assault was committed.]

[Family means **Your** parent, stepparent, **Spouse** or former **Spouse**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.]

[Household means a person who maintains residence at the same address as **You**.]

[This benefit applies [only to the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.][to any willful or unlawful use of force in connection with the commission of or the attempt to commit a crime including, but not limited to, [robbery,][theft,][kidnapping,][hostage-taking,][assault,][battery,][sniping,][murder,][manslaughter,][riot,] or [insurrection]) that: 1.) results in a covered injury; and 2.) is a felony in the jurisdiction in which it occurs.]]

AB13-XX]

[FUNERAL EXPENSE BENEFIT

We will pay an additional benefit for **Funeral Expenses** incurred within [thirty (30)] days of the **Covered Loss**, if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**.

The benefit amount will be equal to the lesser of [5%] of [**Your**] **[**the **Insured Person's**] **Principal Sum** or [$5,000].

AB14-XX]

[**HEARING AID OR PROSTHETIC APPLIANCE BENEFIT**

We will pay an additional benefit, if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Benefit**, provided:

1. [**You** are] **[**the **Insured Person** is] required to use a hearing aid or prosthetic appliance;
2. the **Injury** that caused the payment of the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit** is the same **Injury** that requires [**You**] **[**the **Insured Person**] to use the **Hearing Aid or Prosthetic Appliance**; and
3. the **Hearing Aid or Prosthetic Appliance** is required within [365 days] of the **Injury**.

The amount **We** will pay will be equal to the one time cost of the **Hearing Aid or Prosthetic Appliance** actually paid by [**You**] **[**the **Insured Person**].

This benefit will not be paid unless:

1. the **Hearing Aid or Prosthetic Appliance** was prescribed by a legally qualified **Physician** or surgeon who is not **[Your]** [the **Insured Person's**] spouse, child, or relative; and
2. presentation of proof of payment is provided to **Us**.

For purposes of this benefit, **Prosthetic Appliance** will include an artificial limb or eye.

No payment will be made for ordinary living, traveling or clothing expenses.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [10%] of [**Your**] **[**the **Insured Person's**] **Principal Sum** or [$10,000].

AB15-XX]

[**HIGHER EDUCATION BENEFIT**

We will pay an additional benefit for Higher Education expenses, if **You** [select a **Plan** covering **Your Dependents** and **You** [or **Your Covered Spouse**[/**Domestic Partner**]]] sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to the individual who incurs the expense on behalf of each [**Covered**] **Dependent Child** if:

1. on the date of the **Accident**, the [**Covered**] **Dependent Child** was enrolled as a full-time student in an accredited college, university or trade school; or
2. the [**Covered**] **Dependent Child** was at the 12th grade level and enrolls in an accredited college, university or trade school within [one (1)] year from the date of the **Accident**.

The **Higher Education Benefit** will be equal to the lesser of:

1. [5%] of [**Your Principal Sum] [**the **Principal Sum** of the **Insured Person** who sustained the **Covered Loss]**; or
2. [$5,000].

[If both **You** and **Your Covered Spouse** [/**Domestic Partner**] sustain a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **Higher Education Benefit** will be based on **Your Principal Sum**.]

The **Higher Education Benefit** will be paid annually for up to [four (4)] consecutive years, if:

1. the [**Covered**] **Dependent Child** continues his or her Higher Education ; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the [**Covered**] **Dependent Child** remains enrolled in an institution of higher learning on a full-time basis.

[The maximum amount payable for all eligible [**Covered] Dependent Children** under this benefit is [$20,000].]

[If, at the time of the **Accident**, a **Plan** covering **Your Dependents** was selected, but there are no [**Covered] Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of [$1,000] to the designated beneficiary.]

AB16-XX]

[**HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT**

We will pay an additional benefit for Home Alterations and/or Vehicle Modifications, if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit**, provided:

1. [**You** are] [the **Insured Person** is] required to use a wheelchair to be ambulatory on a permanent basis;
2. the **Injury** that caused the payment of the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit** is the same **Injury** that requires [**You**] [the **Insured Person**] to need the wheelchair; and
3. the cost is incurred within [365 days] of the **Covered Loss**.

The amount **We** will pay will be equal to:

1. the one time cost of alterations to [**Your**] [the **Insured Person's**] primary residence to make it wheelchair accessible and habitable; and
2. the one time cost of modifications necessary to [**Your**] [his or her] motor vehicle to make the vehicle accessible or drivable.

Benefits will not be payable unless:

1. alterations and/or modifications are made by a person or persons experienced in such alterations and/or modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. presentation of proof of payment is provided to **Us**.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [10%] of [**Your**] [the **Insured Person's**] **Principal Sum** or [$10,000].

AB17-XX]

[**NATURAL DISASTER BENEFIT**

We will pay an additional benefit equal to the lesser of [10%] of [**Your]** [the **Insured Person's**] **Principal Sum** or [$10,000], if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]** as a direct result of a **Natural Disaster**.

For purposes of this benefit, **Natural Disaster** means a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or other similar event.

AB18-XX]

[**PARENT CARE**

We will pay an additional benefit for **Parent Care**, if **You** [or **Your Covered Spouse**[/**Domestic Partner**]] sustain an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**. This benefit will be paid in equal shares to each of **Your Dependent Parents** (or his or her legal guardian) [and the **Dependent Parents** (or his or her legal guardian) of **Your Covered Spouse**[/**Domestic Partner**]].

The amount payable for the **Parent Care Benefit** will be [[$5,000.00] per **Dependent Parent**] [[5%] of **Your** [or **Your Covered Spouse's**[/**Domestic Partner's**]] **Principal Sum]** to a maximum of [$40,000.00] for all **Dependent Parents**. Application for this benefit must be made within [ninety (90)] days of the **Covered Loss**.

For purposes of this benefit, **Dependent Parent** means **Your** parent(s) or grandparent(s) [, or the parent(s) or grandparent(s) of **Your Covered Spouse[/Domestic Partner**]] who, at the time of a **Covered Accident**, is receiving support and care provided by **You** [or **Your Covered Spouse**[/**Domestic Partner**]] as evidenced by the most current tax return filed with the government of the United States of America.

AB19-XX]

[RECONSTRUCTIVE SURGERY BENEFIT

We will pay an additional benefit for **Reconstructive Surgery**, if [**You** sustain**] [**an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit**, provided:

1. the **Reconstructive Surgery** is determined to be medically necessary by a **Physician**; and
2. the **Reconstructive Surgery** has taken place within [365 days] of the occurrence of the **Injury**.

The benefit amount will be in excess of any amounts paid or payable by any other plans and will not exceed the lesser of [5%] of [**Your] [**the **Insured Person's] Principal Sum** or [$5,000].

[If benefits are also payable under the **Critical Burn Benefit**, only one benefit will be paid, the largest benefit.]

AB20-XX]

[**REHABILITATION BENEFIT**

We will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training**, if **You** sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit**. The benefit will be in an amount equal to the lesser of:

1. the actual expenses that are incurred within [two (2)] years from the date of the **Accident** for the **Rehabilitation Training**;
2. [$10,000]; or
3. [10%] of **Your Principal Sum**.

Rehabilitation Training means a treatment program that:

1. is prescribed by a licensed **Physician** acting within the scope of his or her license that is approved by **Us** prior to the provision of services;
2. is required due to **Your Injury**; and
3. prepares **You** for an occupation that **You** would not have engaged in except for the **Injury**.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.
AB21-XX]

[SEAT BELT[/AIR BAG] BENEFIT

We will pay an additional benefit [equal to [10%] of the applicable **Principal Sum** up to a maximum] of [$10,000], if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, provided that [**You** were] [the **Insured Person** was]:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

Verification of [**Your**] [the **Insured Person's**] actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

[An additional benefit [equal to [5%] of [**Your**] [the **Insured Person's**] **Principal Sum** to a maximum] of [$5,000], will be paid if [**You** were] [the **Insured Person** was] driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided [**Your**] [the **Insured Person's**] seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.]

[**We** will not pay a **Seat Belt** [or **Air Bag**] **Benefit** if [**You** are**] [**the **Insured Person** is] the operator of a private passenger automobile at the time [**You** incur] [he or she incurs] such **Covered Injury** and is either:

1. under the influence of alcohol;
   a. [**You**] [An **Insured Person**] will be conclusively presumed to be intoxicated if the level of alcohol in [**Your]** [his or her] blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of [**Your**] [the **Insured Person's**] intoxication. Or,

2. under the influence of

   [a [poison,] [fume,] [noxious chemical substance] that was deliberately ingested][;][or][a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.]]

   [a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions.]]

AB22-XX]

[SPOUSE[/DOMESTIC PARTNER] VOCATIONAL TRAINING BENEFIT

We will pay the actual cost of any professional or trade-training program in which **Your** [**Covered**] **Spouse** [**/Domestic Partner**] enrolls, if **You** [select a **Plan** covering **Your Spouse** [**/Domestic Partner**], and **You**] sustain an **Injury** resulting

in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to **Your** [**Covered**] **Spouse** [/**Domestic Partner**], provided:

1. the purpose of the training program is to obtain an independent source of support and maintenance;

2. the actual cost is incurred within [thirty (30)] months from **Your** death; [and

3. the professional or trade training program is licensed by the state.]

The maximum amount payable under this benefit will be [the lesser of [2%] of **Your Principal Sum** or] [$3,000].

AB23-XX]

[**SURVIVOR BENEFIT**

We will pay an additional benefit, if **You** [select a **Plan** covering **Your** [**Dependents**] and **You**,] sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. The benefit will be paid to **Your** [**Covered**] **Spouse** [/**Domestic Partner**]. [If there is no eligible [**Covered**] **Spouse**[/**Domestic Partner**], the benefit will be paid in equal shares to **Your** [**Covered**] **Dependent Child(ren)** or their legal guardian.]

The [monthly] benefit will be equal to [1%] of **Your Principal Sum** [and will be paid for a period of [six (6) months] from the date of the **Covered Loss**].

AB24-XX]

[**THERAPEUTIC COUNSELING BENEFIT**

We will reimburse the expenses for **Therapeutic Counseling**, if **You** [select a **Plan** covering **Your Dependents** and **You** or **Your Covered Dependents**] sustain an **Injury** resulting in a **Covered Loss** that is payable under the [**Accidental Death Benefit] [**or] [**Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, and **You** [or **Your Covered Dependents**] require **Therapeutic Counseling**. The benefit will be paid to the individual who incurs the expense, provided:

1. all terms and conditions of the **Policy** are met;

2. **Therapeutic Counseling** begins within [ninety (90)] days of the **Covered Accident**;

3. **Therapeutic Counseling** expenses are incurred within [one (1) year] from the date of the **Covered Loss**.

Therapeutic Counseling means treatment or counseling provided by a licensed therapist or counselor who is registered or certified to provide psychological treatment or counseling.

The maximum amount payable under this benefit is $[1,000.00] for any one **Covered Accident**.

AB25-XX]

[**TERRORISM BENEFIT**

We will pay an additional benefit equal to the lesser of [10%] of [**Your] [**the **Insured Person's] Principal Sum** or [$30,000], if [**You**] [the **Insured Person**] sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, that was directly caused by an **Act of Terrorism**.

Act of Terrorism means any intentionally violent or forceful act of any person(s), acting on behalf of an organization or group, with the purpose of creating political turmoil or overthrowing any government.

[We may cancel this **Terrorism Benefit** by sending the **Policyholder**, at its most recent address in **Our** records, a [seven (7)] day notice of **Our** intent to cancel. Any unearned premium at the time of a cancellation will be promptly calculated and returned to the **Policyholder** on a pro-rata basis, but the return of the unearned premium is not a condition of cancellation. A change or termination in this benefit will not affect a claim that begins while this benefit is in force.]

AB26-XX]

[**TRAVEL ASSISTANCE**

Travel Assistance will be available to the following **Insured Persons** when they are traveling [[100 miles] or more from their **Principal Residence] [**outside of the U.S.]: [**You** and **Your Spouse** [/**Domestic Partner**] and/or **Child(ren)**, if covered under the **Policy**.] [**You** and **Your Spouse [/Domestic Partner]** and/or **Child(ren)** if **Your Spouse** [/**Domestic**

Partner] and/or **Child(ren)** are with **You** while **You** are covered under the **Policy**. **Your Spouse** [/**Domestic Partner**] and/or **Child(ren)** will not be covered while making a trip without **You**.] The transportation and/or services provided under **Travel Assistance** must be pre-authorized by **Us**. Under the **Policy**, **Travel Assistance** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

Medical Evacuation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care in accordance with **Western Medical Standards**, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**.

For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider. [The maximum amount **We** will pay for this benefit is [$50,000.00].]

[Medical Services
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider duly licensed to provide such services or care in the jurisdiction where the treatment and care are delivered, **We** will pay the lesser of **Our** negotiated rate with such facility or provider, if **We** have a negotiated rate, or the **Reasonable and Customary** expenses incurred by the **Insured Person** [subject to a deductible of $[100.00]], provided that the first treatment or service occurs within [thirty (30)] days of the **Injury** or **Illness**, and the medical expenses are incurred within [365 days] of the **Injury** or onset of **Illness**. **We** must be contacted within [twenty-four (24) hours] of the **Injury** or onset of **Illness** for benefits to be payable.

In addition to exclusions #1 and #2 [and #8] of the TRAVEL ASSISTANCE EXCLUSIONS section below, **We** will not pay for expenses for medical services: 1) that the **Insured Person** is not legally obligated to pay; 2) that are not **Medically Necessary** for the treatment or care of the **Injury** or **Illness**; 3) that are covered by Medicare; [a group health insurance plan sponsored by the **Policyholder**;] [or any other insurance of any kind;] Workers' Compensation, the Defense Base Act, or any other similar Federal or State mandated plan; 4) that are incurred at a Federal, Veterans, State, or Municipal hospital for which the **Insured Person** is not liable; 5) for cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Injury** or **Illness**; 6) for **Custodial Services**; 7) which are more than **Reasonable and Customary**[.][;][8) for any **Pre-Existing Condition** for [365 days] from the earlier of the enrollment or effective date of coverage;][9) for medical treatment or services provided in the United States or its territories.]

For the limited purpose of determining **Our** liability, **We** have the sole right to determine what is **Reasonable and Customary**. [The maximum amount **We** will pay for this benefit is [$5,000.00].]]

Assisted Repatriation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to his or her **Principal Residence**, or to his or her residence in the country where he or she is currently assigned (at his or her option), in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered. [The maximum amount **We** will pay for this benefit is [$25,000.00].]

Post-Recovery Repatriation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending **Physician**. The upgrade will be subject to **Our** sole discretion. [The maximum amount **We** will pay for this benefit is [$10,000.00].]

Return of Remains
If an **Insured Person** dies while on a **Covered Trip**, **We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable. [The maximum amount **We** will pay for this benefit is [$5,000.00].]

Visit to Hospital
If an **Insured Person** is scheduled to be hospitalized for more than [seven (7)] consecutive days while on a **Covered Trip**, **We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Insured Person** to visit the **Insured Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable. [The maximum amount **We** will pay for this benefit is [$5,000.00].]

Return of Child
If an **Insured Person** is traveling with a **Child(ren)**, who is under [nineteen (19)] years of age or a **Child(ren)** who prior to age [nineteen (19)] became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Insured Person** for support and maintenance, while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person**, such **Child(ren)** is left unattended, **We** will arrange for, and cover the cost of, the transport of the **Child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Insured Person**, and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Child(ren)** and attendant, if applicable, for benefits to be payable. [The maximum amount **We** will pay for this benefit is [$5,000.00] per **Child** and [$5,000.00] per attendant.]

Return of Companion
If an **Insured Person** is traveling with a companion while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person** the **Insured Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one-way economy class flight. **We** must pre-authorize such costs for benefits to be payable. [The maximum amount **We** will pay for this benefit is [$5,000.00].]

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide **Travel Assistance** if the **Coverage** is excluded under Section VIII General Exclusions of this **Certificate**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from [the deliberate ingestion of a [poison,] [fume,] [noxious chemical substance][;][or][the use of a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.];]

   [the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions];
3. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with **Western Medical Standards**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Insured Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Insured Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or ASSISTED REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
7. **We** did not pre-authorize the transportation and/or services;
8. [the **Injuries** or **Illness** resulted in whole or in part from the **Insured Person** being intoxicated. An **Insured Person** will be conclusively presumed to be intoxicated if, on or about the time of the incident which required medical treatment, the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle. A

report from a law enforcement officer, medical provider or any similar report will be considered proof of the **Insured Person's** intoxication.]

- **[TRAVEL ASSISTANCE LIMITATIONS**

  Aggregate Limit of Liability per Covered Accident
  [$500,000]]

- **TRAVEL ASSISTANCE DEFINITIONS**

  For purposes of **Travel Assistance** only, the following definitions apply:

  Covered Trip means when an **Insured Person** is traveling more than [[100] miles from his or her **Principal Residence]** [outside of the U.S.] and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

  Illness or **Ill** means a sickness or disease which impairs normal functions of the body.

  [Medically Necessary means essential for diagnosis, treatment or care of the **Injury** or **Illness** for which it is prescribed or performed; meets generally accepted standards of medical practice; and is ordered by a medical provider within the scope of his or her license.]

  [Pre-Existing Condition means a condition for which the **Insured Person** has sought or received medical advice or treatment, or for which medical treatment was recommended, during the [six (6)] months immediately preceding the earlier of the enrollment or effective date of coverage under the **Policy**, subject to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and its regulations.]

  Principal Residence means the legal domicile of the **Insured Person**.

  [Reasonable and Customary means the most common charge made by other hospitals, medical facilities, clinics, and medical providers in the same region or area of the world as the treatment or services provided. If the most common expense for a treatment or service can not be determined, **We** will determine Reasonable and Customary based upon: 1) complexity involved; 2) degree of professional skill required; and 3) any other pertinent factors.]

  Western Medical Standards means generally accepted medical standards comparable to those in the United States, [or Canada] [or Western Europe].

  For the purpose of **Travel Assistance**, if there are any differences in the definition of a term between **Travel Assistance** and the **Policy**, the definition in **Travel Assistance** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

  [Right of Recovery
  We have the right to recover any benefits that **We** have paid under **Travel Assistance** if the **Policyholder** or **Insured Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Insured Person** that were covered under **Travel Assistance**. **We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Insured Person** for transportation services and/or expenses, which were not covered under **Travel Assistance**.**]**

  [Excess Coverage
  Our obligation to pay the **Policyholder** or **Insured Person** under **Travel Assistance** will be excess of any other insurance which the **Policyholder** or **Insured Person** has with respect to the expenses covered under **Travel Assistance**.]

  Reservation of Rights
  We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services [or in any country for which a travel warning has been issued by the Department of State of the United States of America].

  [Exempted Countries

Travel Assistance is not available in the following countries: [named countries]. **We** further reserve **Our** rights to modify this list upon [ten (10)] days notice to the **Policyholder**.]

Scope
[Covered transportation expenses will be limited to air and marine conveyance.]

Illness, as covered under **Travel Assistance**, is solely covered under **Travel Assistance**, and in no way supercedes or modifies the other **Coverages** provided under the **Policy**. All other **Coverages** provided under the **Policy** are available only as a result of a **Covered Injury**.

[To contact **Us** regarding **Travel Assistance**, the **Insured Person** must call [1-866-670-6693] from the U.S. or Canada; and collect from anywhere else in the world at [+1-973-630-6693].]

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[**TRAVEL ASSISTANCE REIMBURSEMENT**

Travel Assistance Reimbursement will apply to the following **Insured Persons** when they are traveling [[100 miles] or more from their **Principal Residence]** [outside of the U.S.]: [**You** and **Your Spouse** [/**Domestic Partner**] and/or **Child(ren)**, if covered under the **Policy**.] [**You** and **Your Spouse**[/**Domestic Partner**] and/or **Child(ren)** if **Your Spouse**[/**Domestic Partner**] and/or **Child(ren)** are with **You** while **You** are covered under the **Policy**. **Your Spouse**[/**Domestic Partner**] and/or **Child(ren)** will not be covered while making a trip without **You**.] Under the **Policy**, **Travel Assistance Reimbursement** consists of the following:

- **TRAVEL ASSISTANCE REIMBURSEMENT BENEFITS**

Medical Evacuation
If an **Insured Person** was **Injured** or **Ill** on a **Covered Trip** and had to be transported to a hospital or medical facility which could treat the **Insured Person**'s medical condition in accordance with generally accepted medical standards of the United States of America [or Canada] [or Western Europe], **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** for such transportation, including special personnel and/or equipment. If **We** determine that a closer hospital or medical facility could have provided medical care consistent with the generally accepted medical standards of the United States of America [or Canada] [or Western Europe], **We** will reimburse the **Policyholder** for the expenses which would have been incurred had the **Insured Person** been transported to that hospital or medical facility, if the cost of transportation would have been less than the actual expenses incurred. [In no case will **We** pay more than [$50,000.00].]

Assisted Repatriation
If an **Insured Person** was **Injured** or **Ill** on a **Covered Trip**, and had to be repatriated to his or her **Principal Residence** or to the country where he or she was assigned, **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** for the non-scheduled commercial air flight, or the additional reasonable expenses incurred for the regularly scheduled air flight, including special personnel and/or equipment, if applicable. (Paragraphs [3] and [4] under TRAVEL REIMBURSEMENT EXCLUSIONS will not apply to this benefit.) If **We** determine that alternative transportation could have been provided without compromising the health of the **Insured Person**, **We** will reimburse the **Policyholder** for the reasonable expenses, or additional reasonable expenses, if applicable, which would have been incurred had the alternative transportation been provided to the **Insured Person**, if the cost of such transportation would have been less than the actual expenses incurred. [In no case will **We** pay more than [$25,000.00].]

Post-Recovery Repatriation
If an **Insured Person** was **Injured** or **Ill** on a **Covered Trip**, and had to be repatriated to his or her **Principal Residence**, or to the country where he or she was assigned due to the **Injury** or **Illness**, **We** will reimburse the **Policyholder** for the reasonable additional expenses incurred by the **Policyholder** to change the original travel date on the return flight and/or an upgrade in the seating. [In no case will **We** pay more than [$10,000.00].] (Paragraphs [3] and [4] under TRAVEL ASSISTANCE REIMBURSEMENT EXCLUSIONS will not apply to this benefit.)

Return of Remains
If an **Insured Person** died while on a **Covered Trip**, **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** for local preparation of the body for transport or cremation (not including the cost of

cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. [In no case will **We** pay more than [$5,000.00].]

Visit to Hospital
If an **Insured Person** was scheduled to be hospitalized for more than [seven (7)] consecutive days while on a **Covered Trip**, **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** for the round trip transportation of the person chosen by the **Insured Person** to visit the **Insured Person** while he or she was hospitalized. [In no case, will **We** pay more than [$5,000.00].]

Return of Child
If an **Insured Person** was traveling with a **Child(ren)**, who is under [nineteen (19)] years of age or a **Child(ren)** who prior to age [nineteen (19)] became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Insured Person** for support and maintenance, while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person**, such **Child(ren)** is left unattended, **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** to transport such **Child(ren**) to the location chosen by the **Insured Person**, including the reasonable expenses incurred for an attendant, if applicable. [In no case will **We** pay more than [$5,000.00] per **Child** and [$5,000] per attendant.]

Return of Companion
If an **Insured Person** was traveling with a companion while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person** the **Insured Person** cannot complete the **Covered Trip** as scheduled, **We** will reimburse the **Policyholder** for the additional reasonable expenses incurred by the **Policyholder** to change the travel date of the companion's return flight. [In no case will **We** pay more than [$5,000.00].]

[Access Fee
We will reimburse the **Policyholder** for the expenses the **Policyholder** incurs to provide access to travel assistance services. [In no case will **We** pay more than [$50,000.00].]]

- **TRAVEL ASSISTANCE REIMBURSEMENT EXCLUSIONS**

  We will not reimburse the **Policyholder** for expenses incurred if such expenses would have been excluded as a **Covered Loss** under the **Policy**, or if:

  1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;

  2. the **Injuries** or **Illness** requiring medical services resulted from

  [the deliberate ingestion of a [poison,] [fume,] [noxious chemical substance][;][or][the use of a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.];]

  [the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions];

  3. based upon **Our** review of a claim, **We** determine that the medical care in the hospital, medical facility, or clinic or by the medical provider was and would have been in accordance with generally accepted medical standards of the United States of America [or Canada] [or Western Europe];

  4. based upon **Our** review of a claim, **We** determine that it was not medically necessary to transport the **Insured Person** to another hospital or medical facility.

  5. [the **Injuries** or **Illness** resulted in whole or in part from the **Insured Person** being intoxicated. An **Insured Person** will be conclusively presumed to be intoxicated if, on or about the time of the incident which required medical treatment, the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle. A report from a law enforcement officer, medical provider or any similar report will be considered proof of the **Insured Person's** intoxication.]

- [**TRAVEL ASSISTANCE REIMBURSEMENT LIMITATIONS**

  Aggregate Limit of Liability per Covered Accident
  [$500,000]]

- **TRAVEL ASSISTANCE REIMBURSEMENT DEFINITIONS**

For purposes of **Travel Assistance Reimbursement** only, the following definitions apply:

Covered Trip means when an **Insured Person** is traveling more than [[100] miles from his or her **Principal Residence]** [outside of the U.S.] and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE REIMBURSEMENT EXCLUSIONS set forth above.

Illness or **Ill** means a sickness or disease, which impairs normal functions of the body.

Principal Residence means the legal domicile of the **Insured Person**.

- **TRAVEL ASSISTANCE REIMBURSEMENT - OTHER PROVISIONS**

[**Excess Coverage**
Our obligation to reimburse the **Policyholder** under **Travel Assistance Reimbursement** will be excess of any other insurance which the **Policyholder** or **Insured Person** has with respect to the expenses covered under **Travel Assistance Reimbursement**.]

[Right of Recovery
We have the right to recover any benefits, which **We** have paid to the **Policyholder** under **Travel Assistance Reimbursement**, if the **Policyholder** recovers any money from a third party for the expenses incurred by the **Policyholder** that were covered under **Travel Assistance Reimbursement**. **We** will be reimbursed from such recovery, and **We** will have a lien against that recovery.]

Scope
[Covered transportation expenses will be limited to air and marine conveyances.]

Illness, as covered under **Travel Assistance Reimbursement**, is solely covered under **Travel Assistance Reimbursement**, and in no way supercedes or modifies the other **Coverages** provided under the **Policy**. All other **Coverages** provided under the **Policy** are available only as a result of a **Covered Injury**.

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SECTION VII – LIMITATIONS

Limitation on Multiple Covered Losses.

We will pay only one benefit, the largest benefit, if [**You** sustain] [an **Insured Person** sustains] more than one loss as a result of the same **Accident**.

Limitation on Multiple Benefits.

The most **We** will pay for the following benefits, in total, is [**Your**] [the **Insured Person's**] **Principal Sum**, if [**You]** [the **Insured Person**] can recover benefits under more than one of these: **Accidental Death Benefit**, [**Accidental Dismemberment** [**and Covered Loss of Use**] [**and Plegia**] **Benefit**,**]** [**Coma Benefit**,] [**Permanent and Total Disability Benefit**,] [**HIV Occupational Accident Benefit**,] [**In-Hospital Indemnity Benefit**] as a result of the same **Accident**.

Limitation on Multiple Hazards.

We will pay only one benefit, the largest benefit [unless there is a specific written exception in the **Policy**], if [**You** sustain] [**an Insured Person** sustains] a **Covered Loss** that is covered under more than one **Hazard**.

[**Aggregate Limit**.

We will not pay more than the **Aggregate Limit of Liability** stated in the Schedule.]

SECTION VIII – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

- [suicide or any attempt at suicide [or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury[**with regard to **Accidental Dismemberment [and Loss of Use][and Plegia] Benefits** only**]]** [including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of autoeroticism or auto-erotic asphyxiation];]
- [war or any act of war, whether declared or undeclared [occurring in the following geographic locations [named countries] only];]
- [involvement in any type of active military service[.] [(Reserve or National Guard active duty training is not excluded, unless it extends beyond [thirty-one (31) consecutive days].)] [(For purposes of this exclusion, orders to active military service for [sixty (60) days] or less will not be considered involvement in active military service.)] [(This exclusion does not apply to the first [sixty (60) consecutive days] of active military service.)];]
- illness or disease [, regardless of how contracted,] ; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; [except for **Accidental** ingestion of contaminated foods];
- [participation in the commission or attempted commission of [a crime,] [any felony,] [an assault,] [insurrection] [or] [riot];]
- [[parasailing,] [bungee jumping,] [heli-skiing,] [scuba diving] [or any other extra-hazardous activity];]
- [[being intoxicated while operating a motor vehicle.]

  [being intoxicated.]

  1. [A **Primary Insured Person**] [An **Insured Person**] will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.

  2. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the [**Primary Insured Person's**] [**Insured Person's**] intoxication.]
- [[the deliberate ingestion of a [poison,] [fume,] [noxious chemical substance][;][or][the use of a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.];]

  [the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions.];]
- [travel or flight in any aircraft except to the extent stated in the **Hazards** Section;]
- [the use or release of [explosives, however delivered,] [nuclear energy,] [radiation,] [chemicals,] [biological agents or diseases,] [an organism or agent which disrupts the environmental or ecological balance of a geographic area] which results directly or indirectly from the intentional or unlawful act of a person or persons, including any resulting sickness or disease;]
- [a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**;]
- [alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a **Physician** operating within his or her scope of authority.]

SECTION IX – CLAIMS PROVISIONS

Notice. You or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within twenty (20) days of such **Covered Loss**. The notice must name **You**, the **Insured Person** who sustained the **Injury**, and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at [866-583-2233.] The notice must be sent to the Claims Department, [Atlantic Specialty Insurance Company] [OneBeacon

Insurance Company], [P.O. Box 1009, Morristown, NJ 07962-1009], or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

Claim Forms. We will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can

send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss**.

Proof of Covered Loss. Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss**, and the proof was provided as soon as reasonably possible.

Time of Payment. We will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

Recipient of Payment.

1. **Your** Loss of Life. **Covered Losses** resulting from **Your** death are paid to **Your** named beneficiary at the time of death. If there is no beneficiary named or **Your** named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to [the beneficiary **You** named for the **Policyholder's** Group Life Insurance policy. If there is no beneficiary named for **Your Policyholder's** Group Life Insurance policy, or **Your** named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to] [**Your** survivors in the following order:
   a. **Your Spouse**[or **Domestic Partner**];
   b. **Your** child(ren);
   c. **Your** parents;
   d. **Your** brothers and sisters;
   e.] **Your** estate.
2. [**Your Covered Dependent's** Loss of Life. **Covered Losses** for the death of **Your Covered Dependent** will be paid to **You**. If **You** pre-decease or die at the same time as **Your Covered Dependent**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to **Your** estate.
3.] All Other Claims. Benefits are to be paid to [**You]** [the **Insured Person**]. [[**You]** [He or she] may direct in writing that all, or part of the **Accident Medical Expense Benefit**, if applicable, will be paid directly to the party who furnished the service. The direction may be changed by [**You**] [the **Insured Person**] at any time up to the filing of the proof of **Covered Loss**.]
[4. If a **Foreign National** is entitled to benefits for a **Covered Loss** and **We** are unable to make payment directly to him or her because of legal restrictions in the country or jurisdiction where such **Foreign National** is located, **We** will either: (1) pay the benefits to a bank account owned by the **Foreign National** in the United States of America; or (2) if no such bank account is established or maintained, **We** will pay the benefits to the **Policyholder** on behalf of the **Foreign National**. It will then be the responsibility of the **Policyholder** to remit the benefit to such **Foreign National**. Payment of the benefit to the **Policyholder** will release **Us** from any further liability to the **Foreign National**. If the **Policyholder** does not remit the payment to the **Foreign National**, the **Policyholder** will indemnify **Us** and hold **Us** harmless against any and all liability incurred by **Us** including, but not limited to, interest, penalties, and attorneys' fees in connection with, arising or resulting from such failure to remit payment. The **Policyholder** will not be considered the beneficiary under the **Policy** if payment is made to the **Policyholder** in accordance with this provision.]

Physical Examination and Autopsy. We have the right to examine [**You**] [the **Insured Person**] when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

Choice of Service Provider. [**You** have] [The **Insured Person** has] the sole right to choose [**Your**] [his or her] duly licensed **Physician** and hospital.

[**Right to Recover Overpayments**. In addition to any rights of recovery or reimbursement provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** will have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to the **Insured Person** (and his or her assignee) under the **Policy** to the extent of the overpayment.]

Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina, Wisconsin and Alabama) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where [**You** live] [the **Insured Person** lives] makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

[**Arbitration.** Any contest to a claim denial under the **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to [**You**] [the **Insured Person**]. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if [**You** are] [the **Insured Person** is] a resident of a state where the law does not allow binding arbitration in an insurance **Policy**, but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of lawsuit by [**You]** [the **Insured Person**].]

SECTION X – GENERAL PROVISIONS

Beneficiaries. You have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. **You** may change the beneficiary at any time unless **You** have assigned the interest in the **Policy**. In such case, the person to whom **You** have assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us**.

Change or Waiver. A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

Clerical Error. A clerical error or omission will not increase or continue **Your Coverage**, which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

Conformity with Statute. Terms of the **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

[**Assignment of Interest.** A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.]

[Incontestability. The validity of the **Policy** will not be contested after it has been in force for two (2) years from the **Policy** Effective Date, except as to nonpayment of premiums.]

SECTION XI – DEFINITIONS

- **Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.
- **Active** or **Actively at Work** describes an employee who is able and available for active performance of all of his or her regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered actively at work provided the employee is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.
- **[Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the **Policy**. For purposes of the Aggregate Limit of Liability provision, **Covered Accident** or **Covered**

  Accidents will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause [occurring within a [one (1)] day period] and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each **Insured Person**, **We** will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.]
- [**Chartered Aircraft** means an aircraft operated by a company with an air carrier or commercial operating certificate issued by the Federal Aviation Administration or the equivalent certificate issued by a foreign government, which the **Policyholder** has the right to use for no more than [ten (10)] consecutive days and/or for no more than [fifteen (15)] days in a [one (1)] year period.]
- [**Controlled** by, as used in the **Hazards** Section, means the **Policyholder** has the right to use a block of aircraft flight time for [25] or more hours in a [one (1)] year period or for [100] hours or more without a specified term, from a company which is in the business of providing aircraft for private use. A **Chartered Aircraft** will not be considered **Controlled** by the **Policyholder**.]
- **Coverage(s)** means the event or events described in the **Hazards** Section **[**and Additional Coverages Section] of this **Certificate** to which benefits and additional benefits apply. The **Hazards** [and Additional Coverages] are listed in the Schedule.
- **Covered Accident** means an **Accident** that results in a **Covered Loss**.
- **Covered Injury** means an **Injury** directly caused by an **Accident**, which is independent of all other causes, results from a **Covered Accident**, occurs while the **Insured Person** is insured under the **Policy**, and results in a **Covered Loss**.
- **Covered Loss** means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury**, and for which benefits are payable under the **Policy**.
- **Dependent** means **Your Spouse** [/**Domestic Partner**] and **Dependent Child(ren)**, as defined in this Section. [The **Dependent** will only be a **Covered Dependent** if **You** select a **Plan** covering **Your Dependents**.]
- **Dependent Child(ren)**, if used in this **Certificate**, means **Your** unmarried **Child(ren)**, [and] [those unmarried **Child(ren)** of **Your Spouse]** [, and those unmarried **Child(ren)** of **Your Domestic Partner** [as defined in the **Policyholder's** [medical] plan as on file with and approved by **Us**]] who rely on **You** for [more than 50% of] their support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap. [**Dependent Child(ren)** will only be **Covered Dependent Child(ren)** if **You** select a **Plan** covering **Your Dependent Child(ren)**.]
- [**Domestic Partner** means [a person who qualifies as a domestic partner under the **Policyholder's** written procedures as on file with and approved by **Us**.] [a person who qualifies as a domestic partner under the law of the state of residence.] [a person as defined in the **Policyholder's** [medical] plan as on file with and approved by **Us**.]]
- [**Domestic Partner**
  To qualify as a domestic partner, the following requirements must be met:
  1. [**You** and **Your** domestic partner must have an intimate, committed relationship of mutual caring, and have agreed to be responsible for each other's welfare;]

2. [**You** and **Your** domestic partner must have lived together in such a relationship for a period of not less than six consecutive months at the same residence address;]
3. [**You** and **Your** domestic partner must both be at least 18 years of age;]
4. [neither **You** nor **Your** domestic partner are legally married;]
5. [**You** and **Your** domestic partner are not related by blood or adoption;]
6. [**You** and **Your** domestic partner are each other's sole domestic partner and intend to remain so indefinitely; and]
7. [**You** and **Your** domestic partner must be of the same sex, and if applicable law permitted, would be married.]

The existence of the relationship between **You** and **Your** domestic partner must be evidenced by:

1. [**Your** domestic partner being named as the primary beneficiary in the event of **Your** death under **Your** retirement plan or 401(k) plan, if **You** maintain such a plan;]
2. [at least one of the following:
   a. designation of **Your** domestic partner as a primary beneficiary under **Your** will; or
   b. designation of **Your** domestic partner as a primary beneficiary for **Your** life insurance;]
3. [at least one of the following:
   a. joint ownership of real estate (whether by mortgage, lease or deed);
   b. joint ownership of a motor vehicle; or
   c. joint ownership of a bank account; and]
4. [a completed, active certification of domestic partner status form on file with the **Policyholder**.]

To have coverage, **You** will not have completed a Termination of Domestic Partner status form with respect to **Your** domestic partner who is to be covered under the **Policy**.]

- [**Foreign National** means a person who is a citizen of a country or jurisdiction other than the United States of America and who is not a resident of the United States of America.]
- **Injured**, **Injury or Injuries** means bodily harm or bodily damage.
- **Insured Person** means any person who has insurance under the terms of the **Policy**. It includes **You** [, and **Your Spouse** [**/Domestic Partner**] and/or **Dependent Child(ren)** if **You** select a **Plan** covering **Your Spouse** [**/Domestic Partner**] and/or **Dependent Child(ren)]**.
- [**Owned Aircraft** means an aircraft in which the **Policyholder** [or a related company] has legal or equitable title. Fractional ownership in a company which is in the business of providing aircraft for private use will be deemed to be equitable title in the aircraft used by the **Policyholder**.]
- **Physician** means a person who is licensed to practice medicine in the jurisdiction in which the medical service or treatment is performed and is acting within the scope of his or her license.
- **Plan** means the plan design as described in the Schedule.
- **Policy** means the Group **Accident** Insurance **Policy**.
- **Policyholder** means the group named on the front page of the **Policy**.
- **Primary Insured Person** means an individual who [has an employment relationship with the **Policyholder**;] is eligible for coverage under the **Policy** as provided in the Eligibility of **Primary Insured Persons** part of Section I[; and who completes the enrollment material].
- [**Service Waiting Period** means the continuous length of time a person is required to be employed by the **Policyholder** prior to being covered under the **Policy**.]
- **[Specialized Aviation Activity** means an aircraft while it is being used for one or more of the following activities:

[acrobatic or stunt flying]	[hanggliding]
[aerial photography]	[hunting]
[banner towing]	[parachuting or skydiving]
[bird or fowl herding]	[pipe line inspection]
[crop dusting]	[power line inspection]
[crop seeding]	[racing]

[crop spraying]
[endurance tests]
[exploration]
[fire fighting]
[flight on a rocket-propelled or rocket launched aircraft]
[flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted]
[skywriting]
[test or experimental purpose]]

- **Spouse**, if used in this **Certificate**, means **Your** legally married **Spouse** [under age 70]. [**Your Spouse** will only be a **Covered Spouse** if **You** select a **Plan** covering **Your** eligible **Spouse**.]
- [**Under lease**, as used in the **Hazards** Section, means an aircraft which the **Policyholder** does not own but has the right to use, under a written agreement, for more than [ten (10)] consecutive days and/or for more than [fifteen (15)] days in a [one (1)] year period. A **Chartered Aircraft** will not be considered **Under lease**.]
- **We**, **Us** and **Our** refers to [Atlantic Specialty Insurance Company] [OneBeacon Insurance Company].
- **You** and **Your** refers to the **Primary Insured Person**.

In Witness Whereof, We have caused the Policy to be executed and attested, and, if required by state law, the Policy shall not be valid unless countersigned by Our authorized representative.

Dennis R. Smith, Secretary
[Atlantic Specialty Insurance Company]
[OneBeacon Insurance Company]

Michael Miller, President & CEO
[Atlantic Specialty Insurance Company]
[OneBeacon Insurance Company]

Countersigned _____
Authorized Representative Date

GROUP [BASIC][BUSINESS TRAVEL][VOLUNTARY] ACCIDENT CERTIFICATE OF INSURANCE

FOR

EMPLOYEES OF [POLICYHOLDER]

THIS INSURANCE PROVIDES COVERAGE FOR LOSSES DUE TO ACCIDENTS ONLY.

IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR LOSSES DUE TO SICKNESS.

[Atlantic Specialty Insurance Company]
[1 Beacon Lane
Canton, MA 02021-1030]

POLICYHOLDER: **[ABC Company]**

POLICY NUMBER: **[1234567]**

[COVERED SUBSIDIARIES OR AFFILIATED COMPANIES **[Names of Companies]]**

The insurance evidenced by this Certificate provides Accident insurance only. It does not provide Coverage for sickness. This Certificate describes the main features of the Policy, but the Policy is the only contract under which benefit payments are made. If there is an inconsistency between the Certificate and the Policy, the Policy will govern.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT

CERTIFICATE OF INSURANCE

Table of Contents

SECTION I – ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

CERTIFICATE HOLDER.

Class	Description
[1]	[All **Active** [full-time][and part-time]employees of the **Policyholder** working a minimum of [30] hours per week [who have completed the required **Service Waiting Period** indicated below] [and who have completed enrollment material on file with the **Policyholder**].]
[2]	[All **Active** [Union][non-Union] employees of the **Policyholder** [who have completed the required **Service Waiting Period** indicated below] [and] [who have completed enrollment material on file with the **Policyholder**].]
[3]	[As determined by the **Policyholder's** written human resource policy for benefit eligibility, with respect to Accident coverage, as of the effective date of the **Policy** [who have completed the required **Service Waiting Period** indicated below] [and] [who have completed enrollment material on file with the **Policyholder**].]

[If **You** sustain an **Injury** resulting in a **Covered Loss**, and **You** are covered under more than one Class, only one benefit will be paid, the largest benefit.]

Effective Date. [A. If **You** are hired prior to [January 1, 2007]:
[January 1, 2007], provided the completed enrollment material is received by the **Policyholder** on or prior thereto.

B. If **You** are hired on or after [January 1, 2007]:
[on the first day of the month following the date the completed enrollment material is received by the **Policyholder**] [upon completion of the required **Service Waiting Period** indicated below, provided the completed enrollment material is received by the **Policyholder** prior thereto] [on the first day of the month following completion of the required **Service Waiting Period** indicated below, provided the completed enrollment material is received by the **Policyholder** prior thereto].]

[A. If **You** are hired prior to [January 1, 2007]:
the later of the **Policy** effective date or upon completion of the required **Service Waiting Period**, if any, indicated below.

B. If **You** are hired on or after [January 1, 2007]:
the later of the first day of **Active** work or upon completion of the required **Service Waiting Period**, if any, indicated below.]

[A. If **You** are hired prior to [January 1, 2007]:
Your first day of **Active** work following the effective date of the **Policy**.

B. If **You** are hired on or after [January 1, 2007]:
Your first day of **Active** work following **Your** date of hire.]

[If **You** are not **Actively at Work** on **Your** Effective Date of coverage, coverage will begin on **Your** first full day of **Active** work following **Your** Effective Date.]

[Service Waiting Period. [None.] [[thirty (30)] days of **Active** continuous service.] [As per the **Policyholder's** then written plan.]]

Termination Date. [Your coverage terminates at the end of the [month][period] for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;

2. **You** cease to be eligible for coverage;

3. **You** fail to pay the required premium, if **You** are so required [;][.]
4. [**You** reach age [70]][;][.]
5. [**You** retire.]]

[**Your** coverage automatically terminates on the earliest of:

1. the date the **Policy** is terminated;
2. the date **You** cease to be eligible for coverage;
3. the expiration date of the period for which required premium has been paid for **You**;
4. the date **You** fail to pay the required premium, if **You** are so required[;][.]
5. [the date **You** reach age [70]][;][.]
6. [the date **You** retire.]]

[If **You** have received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written policy, **Your** insurance under the **Policy** will continue, provided the required premiums are paid. This extension of coverage is subject to all of the termination provisions of the **Policy** with the exception of number 2. above.]

[**Conversion Coverage**. If **Your** insurance ceases for reasons other than termination of the **Policy** [or non-payment of premium], **You** are entitled to purchase **Conversion Coverage** under a conversion group policy. [**You** may also purchase **Conversion Coverage** for **Your Dependents**, if such **Dependents** were covered under the **Policy** at the time insurance ceases.] The conversion group policy will be on **Our** approved forms and will only provide **Accidental Death Benefits** [and **Accidental Dismemberment** [and **Covered Loss of Use**][and **Plegia**] **Benefits**].

Written application for **Conversion Coverage** must be made within [sixty (60)] days of the cessation of insurance under the **Policy**. [To request an application form, **You** must [call [1-800-527-1255]] [or write to **Us** at [44 Whippany Road, Morristown, NJ 07960]].] **You** [and **Your Covered Dependents**, if applicable,] are not required to show proof of good health.

The issuance of **Conversion Coverage** is subject to the following conditions:

1. the **Principal Sum** will be the lesser of:
   a. **Your Principal Sum** under the **Policy** [, rounded to the next higher [$10,000], if not already a multiple thereof,] [, but the amount may not be less than [$50,000].] [In the event that **You** have a **Principal Sum** in an amount less than [$100,000], **You** may continue that amount or increase the amount to [$100,000].][;] Or,
   b. [$250,000];
2. the premium for the group conversion policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. coverage under the conversion group policy will take effect on the termination date of **Your** coverage under the **Policy**; and
4. when coverage under the conversion group policy becomes effective, the relationship between **You** and **Us** will be governed by that policy, including all terms and conditions, and benefits and termination dates.

[Eligibility for **Conversion Coverage** will cease when **You** attain age [seventy (70)].]

[**Conversion Coverage** is only available to **You** if **You** are a resident of the United States at the time **Conversion Coverage** is purchased.]

[**Conversion Coverage** is [not] available for residents of [named states].]

[**Covered Loss During the Conversion Coverage Application Period**. If **You** sustain an **Injury** resulting in a **Covered Loss** that would have been payable under the **Accidental Death Benefit [or Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, within the [sixty (60] day **Conversion Coverage** application period, **We** will pay the **Principal Sum** amount that would have been paid under the **Policy**. This benefit will be paid regardless of whether **You** had applied to purchase **Conversion Coverage** at the time of **Your Covered Loss**.]]

[**Portability Coverage**

If **Your** insurance ceases for reasons other than [non-payment of premium or] cancellation of the **Policy**, **You** have the right to continue **Coverage** under the **Policy**, [even if the **Policy** is subsequently canceled or terminated for any reason] [provided the **Policy** is not subsequently canceled or terminated.]

This **Portability Coverage** is subject to the following conditions:

1. written notice to **Us** of **Your** election to continue **Coverage** and the initial premium, must be received by **Us** within [sixty (60)] days of the event causing the termination of **Your** insurance, along with **Your** home and billing address, if different.

2. **You** may elect to continue the same **Principal Sum** [rounded up to the next higher [$10,000]] [to a maximum of [$250,000]][but the amount may not be less than [$50,000]]. In the event that **You** have a **Principal Sum** in an amount less than [$100,000], **You** may continue that amount or increase the amount to [$100,000]. [The maximum **Principal Sum** under this **Portability Coverage** will be [$250,000.]]

3. upon receipt of the written notice, **We** will provide **You** with a **Certificate** Endorsement to be attached to **Your Certificate of Insurance**, which will provide the Initial **Portability Coverage** Period beginning with the termination date of **Your** coverage under the **Policy**.

4. the initial premium will be based upon the Portability rates which appear in the Premium Section of the **Policy**. [**We** reserve the right to change the premium.]

[Eligibility for **Portability Coverage** will cease when **You** attain age [seventy (70)].]

[If the insurance of **Your Covered Spouse [/Domestic Partner]** ceases because of the **Your** death while **Portability Coverage** is in effect, **Your Covered Spouse [/Domestic Partner]** may apply to continue **Portability Coverage**. **Your Covered Spouse [/Domestic Partner**] will be eligible for the amount of **Principal Sum** he or she had in force under the **Portability Coverage**. Written application for continuation of **Portability Coverage** must be made within [sixty (60)] days of the cessation of **Your Covered Spouse's [/Domestic Partner's**] insurance under **Portability Coverage**.]

[**Portability Coverage** is [only] available for residents of [named states].]

[**Covered Loss During the Portability Coverage Application Period**. If **You** sustain an **Injury** resulting in a **Covered Loss** that would have been payable under the **Accidental Death Benefit [or Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, within the [sixty (60] day **Portability Coverage** application period, **We** will pay the **Principal Sum** amount that would have been paid under the **Policy**. This benefit will be paid regardless of whether **You** had applied to purchase **Portability Coverage** at the time of **Your Covered Loss**.]]

[CERTIFICATE HOLDER'S DEPENDENTS.

Eligibility. Individuals who enroll may elect to cover their eligible **Dependents**. An eligible **Dependent** includes **Your Spouse**[/**Domestic Partner**] and **Your Dependent Child(ren)**, [and] [**Your Spouse's Dependent Child(ren)]** [, and **Your Domestic Partner's Dependent Child(ren)**]. [**Your Spouse**[/**Domestic Partner**] will not be eligible as a **Dependent** if he or she is also a **Primary Insured Person** under the **Policy**.] [If **You** and **Your Spouse [/Domestic Partner]** or former **Spouse**[/**Domestic Partner**] are both **Primary Insured Persons** under the **Policy**, only one may select a **Plan** covering **Your** mutual **Dependents**.]

Effective Date. Dependent coverage begins on the later of:

1. the date **Your** coverage begins, provided **You** requested **Dependent Coverage** on **Your** enrollment materials;

2. the date **You** request to add coverage for **Your** eligible **Dependents** in the applicable benefit materials; or

3. the date he or she becomes an eligible **Dependent**.

Termination Date. [Coverage terminates at the end of the [month][period] for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;

2. **Your Dependent** ceases to be eligible for insurance;

3. **Your** coverage terminates, except in such situations where the written policy of the **Policyholder** allows **You** to continue coverage for **Your Covered Dependents**;
4. **You** fail to pay the required premium, if **You** are so required[;][.]
5. [for the **Covered Spouse[/Domestic Partner**] only, **Covered Spouse[/Domestic Partner** reaches age [70].]]

[Coverage automatically terminates on the earliest of:

1. the date the **Policy** is terminated;
2. the date **Your Dependent** ceases to be eligible for coverage;
3. the date **Your** coverage terminates, except in such situations where the written policy of the **Policyholder** allows **You** to continue coverage for **Your Covered Dependents**;
4. the expiration date of the period for which the required premium has been paid for such **Dependent**;
5. the date **You** fail to pay the required premium, if **You** are so required[;][.]
6. [for the **Covered Spouse[/Domestic Partner**] only, the date the **Covered Spouse[/Domestic Partner** reaches age [70].]]

[If **You** have received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written policy, insurance for **Your Covered Dependents** under the **Policy** may continue, provided the required premiums are paid. This extension of coverage **is** subject to all of the termination provisions of the **Policy** with the exception of number 2. above.]

[Notwithstanding the forgoing provisions, the **Policy** will conform to the **Policyholder's** written policy with respect to accident coverage with regard to eligibility for coverage, continuation of coverage, and termination of coverage as in force on the effective date of the **Policy**.]

SECTION II – SCHEDULE

HAZARDS

The following are the **Hazards** for which insurance applies:

[All Classes]	[including their **Covered Dependents**]:]
	[24 Hour **Accident** Protection, Business and Pleasure, Excluding Corporate Owned or Leased Aircraft]
[Class 1]	[and their **Covered Dependents**]:] [24 Hour **Accident** Protection while on a **Specified Trip**]

Additional Coverages

[Class 2]	[and their **Covered Dependents**]:]	[Felonious Assault Coverage]

BENEFITS

A. Principal Sum

The following are the **Principal Sums** for each Class:

[Class 1]	[An employee may purchase an amount of **Principal Sum** from a minimum of [$50,000] to a maximum of [$500,000] in increments of [$10,000]. [However, amounts applied for in excess of [$150,000] must not exceed [ten (10)] times the employee's **Base Annual Earnings***.]]
[Class 2]	[[Three (3)] times the employee's **Base Annual Earnings*** to a maximum of [$500,000].]
[Class 3]	[$100,000]
[Class 4]	[as on file with the **Policyholder** and **Us**]

[*__Base Annual Earnings__ means the employee's base annual pay [excluding overtime, bonuses, [commissions] and special compensation.]]

[The following are the **Principal Sums** for **Covered Dependents**:

[The **Principal Sum** for **Covered Dependents** will be a percentage of the employee's **Principal Sum**:

Plan Selected	**% Spouse[/Domestic Partner]**	**% Child(ren)**
Spouse[/Domestic Partner] only:	[50%]	0
Dependent Child(ren) only:	0	[15%]
Spouse[/Domestic Partner] and **Dependent Child(ren)**	[40%]	[10%]

[Maximum of [$25,000] [**Principal Sum**] [**Accidental Death Benefit**] for **Dependent Child(ren)**.]

[For **Covered Dependent Child(ren)**, the indicated percentage applies to loss of life only.]

[In no event will the amount be greater than **Your Principal Sum**.]]

[The **Principal Sum** for **Covered Dependents** will be [a choice of] the following amounts:

Spouse[/Domestic Partner]: [$50,000] [$75,000] [$100,000]

Dependent Child(ren): [$10,000] [$15,000] [$20,000] [$25,000]

[In no event will the amount be greater than **Your Principal Sum**.]]

[Principal Sum Reduction

[At age [70], [for **You** only,] the **Principal Sum** will be reduced based on [**Your**] [the **Insured Person's**] previous **Principal Sum** per the following schedule:

Age at Date of Loss	**Percent of Principal Sum**
[70-74]	[65%]
[75-79]	[45%]
[80-84]	[30%]
[85 & Over]	[15%]]

[Aggregate Limit of Liability

[The **Aggregate Limit of Liability** per [air travel] **Covered Accident** is [$0.00].]

[The **Aggregate Limit of Liability** per [on-premises Felonious Assault Coverage,][On-Premises Terrorism Coverage,][War Risk Coverage,][on-premises Bomb Scare/Explosion Coverage] **Covered Accident** [combined] is [$0.00].]]

[**Escalator Clause**

We will increase **Your Accidental Death Benefit** at an amount equal to [2%] of **Your Principal Sum** for each year **You** remain continuously covered under the **Policy** for a maximum of [five (5)] years. [If **You** selected a **Plan** covering **Your Dependent(s)**, the **Principal Sum** for **Your Covered Dependent(s)** will be calculated from **Your** original **Principal Sum**, and therefore this increase does not affect **Your Covered Dependent's Accidental Death Benefit(s)**.]

The first increase will take effect one year from the **Policy** anniversary date that is equal to or later than the date **You became** eligible for benefits under the **Policy**. Future increases will take effect on subsequent **Policy** anniversary dates. The increase will be based on **Your Principal Sum** on the day immediately prior to the **Policy** anniversary date.]

B. Accidental Death Benefit

This benefit applies to [all Classes of **Primary Insured Persons** [and their **Covered Dependents**]] **[**Class 1 [and their **Covered Dependents**]] [Classes 2 and 3 [and their **Covered Dependents**]].

C. [Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Benefit

This benefit applies to [all Classes of **Primary Insured Persons** [and their **Covered Dependents**]] **[**Class 1 [and their **Covered Dependents**]] [Classes 2 and 3 [and their **Covered Dependents**]]

D. [Coma Benefit]

This benefit applies to [all Classes of **Primary Insured Persons** [and their **Covered Dependents**]] **[**Class 1 [and their **Covered Dependents**]] [Classes 2 and 3 [and their **Covered Dependents**]]

E. [Additional Benefits

[All Classes [including their **Covered Dependents**]:]	[Seat Belt Benefit]
	[Rehabilitation Benefit]
	[Accident Weekly Indemnity Benefit]
[Class 1 [and their **Covered Dependents**]:]	[Accident Medical Benefit]]

[ENDORSEMENTS

The following Endorsements have been attached to and are included in the **Policy**:

[Administrative Change Endorsement] [Endorsement No. [1]] [XX 12345] [for: Class 2]]

SECTION III – HAZARDS

[24 HOUR ACCIDENT PROTECTION, BUSINESS AND PLEASURE
[EXCLUDING] [INCLUDING] CORPORATE OWNED OR LEASED AIRCRAFT,
[AND SUBSTITUTE AIRCRAFT,]
[PASSENGER ONLY] [PASSENGER AND CREW]

The **Policy** insures against the following **Hazards**:

A **Covered Injury** sustained by [**You**] [an **Insured Person**] [anywhere in the world], subject to the terms, conditions, exclusions and limitations under the **Policy**.

[Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a trip, while [**You** are] [the **Insured Person** is] [a passenger,] [pilot, operator, member of the crew or cabin attendant,] riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
   - **a.** medical certificate; and
   - **b.** pilot certificate with a proper rating to pilot such aircraft.
2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.]

[Hazard Exclusions:

Coverage is not provided:

1. [If [**You** are**]** [the **Insured Person** is] the pilot, operator, member of the crew or cabin attendant of any aircraft [except those aircraft specified below].]
2. [Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   - **a. [**any aircraft other than those expressly stated in this **Hazard**;]

b. [any aircraft [**Owned** or] [**Controlled** by, or] [**Under lease** to] the **Policyholder** [except the following aircraft, [including **Substitute Aircraft**]:

[Description of Aircraft]

provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least [1,000] hours as a pilot of which at least [500] hours were logged in this or the same class of aircraft.]]

c. [any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured Person** [or a member of an **Insured Person's** [family or] household];]

d. [any aircraft operated by [the **Policyholder** [except those indicated in b. above, [including **Substitute Aircraft**]]or] one of the **Policyholder's** employees [including members of an employee's [family or] household];]

e. [any aircraft engaged in a **Specialized Aviation Activity**;**]**

f. [any conveyance [except aircraft] used [for tests or experimental purposes, [or]] [in a race or speed test].]]]

[**Hazard Definitions:**

[**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:

1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;

2. is the same class of aircraft as the specified aircraft; and

3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.]]

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII Limitations and Section VIII General Exclusions.

H1-XX]

[24 HOUR ACCIDENT PROTECTION WHILE ON BUSINESS TRIP,
[EXCLUDING] [INCLUDING] CORPORATE OWNED OR LEASED AIRCRAFT,
[AND SUBSTITUTE AIRCRAFT,]
[PASSENGER ONLY] [PASSENGER AND CREW]

The Policy insures against the following **Hazards**:

A **Covered Injury** sustained by **You [**anywhere in the world] while on the **Business of the Policyholder** [during a business trip] [and during a **Bona Fide Trip**], subject to the terms, conditions, limitations and exclusions under the **Policy**.

Coverage, subject to limitations and exclusions, is provided between:

1. the later of the time **You** leave the place where **You** normally work or live; and

2. the earlier of the time **You** return to the place where **You** normally work or live.

[Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a trip, while **You** are [a passenger,] [pilot, operator, member of the crew or cabin attendant,] riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:

a. medical certificate; and

b. pilot certificate with a proper rating to pilot such aircraft.

2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.]

[Hazard Exclusions:

Coverage is not provided:

1. [If **You** are the pilot, operator, member of the crew or cabin attendant of any aircraft [except those aircraft specified below].]
2. [For an assignment by the **Policyholder** or relocation that exceeds [sixty (60)] days in duration. Note: If an assignment exceeds [sixty (60)] days in duration, the location of the assignment will be considered the place of permanent assignment, and **You** will then have **Coverage** when traveling elsewhere on the **Business of the Policyholder**.]
3. [Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   a. **[**any aircraft other than those expressly stated in this **Hazard**;]
   b. [any aircraft [**Owned** or] [**Controlled** by, or] [**Under lease** to] the **Policyholder** [except the following aircraft, [including **Substitute Aircraft**]:

      [Description of Aircraft]

      provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least [1,000] hours as a pilot of which at least [500] hours were logged in this or the same class of aircraft.]]
   c. [any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured Person** [or a member of an **Insured Person's** [family or] household];]
   d. [any aircraft operated by [the **Policyholder** [except those indicated in b. above, [including **Substitute Aircraft**]]or] one of the **Policyholder's** employees [including members of an employee's [family or] household];]
   e. [any aircraft engaged in a **Specialized Aviation Activity**;]
   f. [any conveyance [except aircraft] used [for tests or experimental purposes, [or]] [in a race or speed test].]]]

Hazard Definitions:

- **Business of the Policyholder** means an assignment by or at the direction of the **Policyholder** to further the business of the **Policyholder**. It does not include an **Accident** occurring during usual travel to and from work; bona fide leaves of absence or vacation [; or **Personal Deviations/Side Trips** of a personal nature]. [It does not include employees who are hired to operate a truck.] [It does include **Personal Deviations/Side Trips** of a personal nature.]
- [**Bona Fide Trip** means a trip that requires **You** to travel outside the limits of the city or municipality where **You** normally work.]
- [**Personal Deviations/Side Trips** means non-business activities and/or travel of a personal nature, undertaken while on the **Business of the Policyholder**, but unrelated to furthering the **Business of the Policyholder** that: 1) is incidental to the business trip; 2) would not have been taken if not for the business trip; [and] 3) is taken during the course of the business trip[.] [; and 4) is limited to [72 hours]].]
- [**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:
  1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
  2. is the same class of aircraft as the specified aircraft; and
  3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.]

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII Limitations and Section VIII General Exclusions.

H2-XX]

[24 HOUR ACCIDENT PROTECTION WHILE [ON A SPECIFIED TRIP][ATTENDING A SPECIFIED EVENT],
[EXCLUDING] [INCLUDING] CORPORATE OWNED OR LEASED AIRCRAFT,
[AND SUBSTITUTE AIRCRAFT,]
[PASSENGER ONLY] [PASSENGER AND CREW]

The **Policy** insures against the following **Hazards**:

A **Covered Injury** sustained by **You** during a specified [trip] [event], subject to the terms, conditions, limitations and exclusions under the **Policy**, during a specified [trip] [event] to:

[insert destination/description of trip]

Coverage, subject to limitations and exclusions, is provided between

[**1.** the later of the time **You** leave the place where **You** normally work or live; and

2. the earlier of the time **You** return to the place where **You** normally work or live.]

[**1.** the time **You** arrive at the exact location of the specified [trip] [event] ; and

2. the time **You** leave the exact location of the specified [trip] [event].]

[Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during the [trip] [event], while **You** are [a passenger,] [pilot, operator, member of the crew or cabin attendant,] riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
   a. medical certificate; and
   b. pilot certificate with a proper rating to pilot such aircraft.

2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.]

[Hazard Exclusions:

Coverage is not provided:

1. [If **You** are the pilot, operator, member of the crew or cabin attendant of any aircraft [except those aircraft specified below].]

2. [For **Your** travel or activities, which deviate from the requirements for [making the specified trip] [attending the specified event], or travel that is an extension of the specified [trip] [event]. [This includes [**Personal Deviations/Side Trips** of a personal nature.] [This does not include **Personal Deviations/Side Trips** of a personal nature.]]

3. [Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   a. [any aircraft other than those expressly stated in this **Hazard**;]
   b. [any aircraft [**Owned** or] [**Controlled** by, or] [**Under lease** to] the **Policyholder** [except the following aircraft, [including **Substitute Aircraft**]:

   [Description of Aircraft]

   provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has logged at least [1,000] hours as a pilot of which at least [500] hours were logged in this or the same class of aircraft.]]
   c. [any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured Person** [or a member of an [family or]household];]
   d. [any aircraft operated by [the **Policyholder** [except those indicated in b. above, [including **Substitute Aircraft**]]or] one of the **Policyholder's** employees [including members of an employee's [family or] household];]
   e. [any aircraft engaged in a **Specialized Aviation Activity**;]

f. [any conveyance [except aircraft] used [for tests or experimental purposes, [or]] [in a race or speed test].]]]

[**Hazard Definitions:**

- [**Personal Deviations/Side Trips** means non-business activities and/or travel of a personal nature, undertaken while [on the specified trip] [attending the specified event], but unrelated to the specified [trip] [event] that: 1) is incidental to the specified [trip][event]; 2) would not have been taken if not for the specified [trip][event]; [and] 3) is taken during the course of the specified [trip][event][.] [; and 4) is limited to [72 hours]].]
- [**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:
  1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
  2. is the same class of aircraft as the specified aircraft; and
  3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.]]

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII Limitations and Section VIII General Exclusions.

H3-XX]

[FULL OCCUPATIONAL COVERAGE, [EXCLUDING] [INCLUDING] CORPORATE OWNED OR LEASED AIRCRAFT, [AND SUBSTITUTE AIRCRAFT,] [PASSENGER ONLY] [PASSENGER AND CREW]

The **Policy** insures against the following **Hazards**:

A **Covered Injury** sustained by **You [**anywhere in the world] while on or off the premises of the **Policyholder** performing the usual and customary duties of **Your** regular occupation, or while on the **Business of the Policyholder** during a **Bona Fide Trip**, subject to the terms, conditions, limitations and exclusions under the **Policy**.

[Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a **Bona Fide Trip**, while **You** are [a passenger,] [pilot, operator, member of the crew or cabin attendant,] riding in or on, boarding or getting off:

1. any civilian aircraft with a current and valid, normal, transport or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. The aircraft must be operated by a pilot with a current and valid:
   a. medical certificate; and
   b. pilot certificate with a proper rating to pilot such aircraft.
2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.]

[Hazard Exclusions:

Coverage is not provided:

1. [If **You** are the pilot, operator, member of the crew or cabin attendant of any aircraft [except those aircraft specified below].]
2. [Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
   a. [any aircraft other than those expressly stated in this **Hazard**;]
   b. [any aircraft [**Owned** or] [**Controlled** by, or] [**Under lease** to] the **Policyholder** [except the following aircraft, [including **Substitute Aircraft**]:

   [Description of Aircraft]

   provided such aircraft: a) has a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor; b) is being operated with the **Policyholder's** consent; c) is not carrying persons for hire; and d) is being operated by a pilot with a current and valid medical certificate, and pilot certificate with a proper rating to pilot such aircraft and each pilot has

logged at least [1,000] hours as a pilot of which at least [1,000] hours were logged in this or the same class of aircraft.]]

c. **[**any aircraft **Owned** or **Controlled** by, or **Under lease** to an **Insured Person** [or a member of an **Insured Person's** [family or] household];]

d. [any aircraft operated by [the **Policyholder** [except those indicated in b. above, [including **Substitute Aircraft**]]or] one of the Policyholder's employees [including members of an employee's [family or] household];]

e. [any aircraft engaged in a **Specialized Aviation Activity**;**]**

f. [any conveyance [except aircraft] used [for tests or experimental purposes, [or]] [in a race or speed test].]]]

Hazard Definitions:

- **Bona Fide Trip** means a trip that begins when **You** leave the place where **You** normally work or live (whichever last occurs) to go on the trip. It ends when **You** return from the trip to the place where **You** normally work or live (whichever occurs first).
- **Business of the Policyholder** means while on assignment by or at the direction of the **Policyholder** to further the **Business of the Policyholder**. It does not include an **Injury** sustained during:
  1. usual travel to and from work;
  2. leaves of absence or vacations[.] [; or
  3. [**Personal Deviations/Side Trips** of a personal nature, during a **Bona Fide Trip**, that are not at the direction of and in furtherance of the economic interest of the **Policyholder**.]

  [It does not include employees who are hired to operate a truck.]

  [It does include **Personal Deviations/Side Trips** of a personal nature.]
- **[Personal Deviations/Side Trips** means non-business activities and/or travel of a personal nature, undertaken while on the **Bona Fide Trip**, but unrelated to the **Bona Fide Trip** that: 1) is incidental to the **Bona Fide Trip**; 2) would not have been taken if not for the **Bona Fide Trip**; [and] 3) is taken during the course of the **Bona Fide Trip**[.] [; and 4) is limited to [72 hours]].]
- [**Substitute Aircraft** means an aircraft, which is not owned by the **Policyholder**, and:
  1. has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government;
  2. is the same class of aircraft as the specified aircraft; and
  3. is being used by the **Policyholder** because the specified aircraft is withdrawn from use due to breakdown, repair, servicing, loss or destruction.]

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII Limitations and Section VIII General Exclusions.
H4-XX]

SECTION IV – ADDITIONAL COVERAGES

[**SPECIFIED PILOT COVERAGE**

The **Hazard** Exclusion in [**24 Hour Accident Protection**, **Business and Pleasure** [**Excluding**][**Including**] **Corporate Owned or Leased Aircraft**, [**and Substitute Aircraft**,] [**Passenger Only**] [**Passenger and Crew**]] [**24 Hour Accident Protection While on Business Trip**, [**Excluding**] [**Including**] **Corporate Owned or Leased Aircraft**, [**and Substitute Aircraft**,][**Passenger Only**] [**Passenger and Crew**]] [**24 Hour Accident Protection While [on a Specified Trip**] [**Attending a Specified Event**], [**Excluding**] [**Including**] **Corporate Owned or Leased Aircraft** [**and Substitute Aircraft**,] [**Passenger Only**] [**Passenger and Crew**]] [**Full Occupational Coverage**, [**Excluding**] [**Including**] **Corporate Owned or Leased Aircraft**, [**and Substitute Aircraft**,] [**Passenger Only**] [**Passenger and Crew**]] stating that **"Coverage** is not provided: **1.** if [**You** are][the **Insured Person** is] the pilot, operator, member of the crew or cabin attendant of any aircraft." is modified to provide **Coverage** for the following named pilot(s) only:

[**Pilot Name**(**s**)]

while piloting the following aircraft:

[**Aircraft Description(s)**]

provided such aircraft has a current and valid normal, commuter, or transport type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor, and the above named pilot(s) has a current and valid medical certificate and pilot certificate with a proper rating to fly such aircraft.

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C1-XX]

[**BOMB SCARE/EXPLOSION COVERAGE**

Coverage is extended to include a **Covered Injury** caused by, or resulting from, a **Bomb Scare**, **Bomb Search**, **Bomb Explosion** [or **Fire Drill**] occurring on the premises of the **Policyholder**, subject to the following definitions:

- **Bomb** means any real or imitative explosive device placed with intent to cause injury, damage or scare.
- **Scare** means any real or false report of the presence of a **Bomb** on the premises of the **Policyholder**.
- **Search** means any organized search for a reported **Bomb**.
- **Explosion** means any explosion of a **Bomb** on the **Policyholder's** premises whether or not the presence of a **Bomb** was reported in advance.
- [**Fire Drill** means while participating in a **Fire Drill** conducted by the **Policyholder** for the purpose of emergency preparedness.]

[For purposes of on-premises **Bomb Scare/Explosion Coverage**, [as well as [[on-premises] Felonious Assault Coverage,][On-Premises Terrorism Coverage,][War Risk Coverage,]] the **Aggregate Limit of Liability** per **Covered Accident** [combined] is [$0.00].]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C2-XX]

[**COMMUTATION COVERAGE**

Coverage is extended to include a **Covered Injury** sustained by **You** while commuting directly to or from **Your** home and place of regular employment. This **Coverage** begins when **You** leave **Your** home or place of work. This **Coverage** ends when **You** arrive at **Your** home or place of work.

Except for events beyond **Your** control, excluded **Injuries** are those arising out of or in the course of any deviation from **Your** normal route for personal reasons.

[This **Coverage** will not be extended if **You** are the operator of a private passenger automobile at the time **You** incur such **Covered Injury**, and **You** are either:

1. under the influence of alcohol;
   a. **You** will be conclusively presumed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of **Your** intoxication. Or,
2. under the influence of

   [a [poison,] [fume,] [noxious chemical substance]that was deliberately ingested][;][or][a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.]]

   [a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions.]]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C3-XX]

EXPOSURE AND DISAPPEARANCE COVERAGE

If [**You** are] [an **Insured Person** is] exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which [**You** are] [an **Insured Person** is] riding disappears, is wrecked, or sinks, and [**You** are] [the **Insured Person** is] not found within [365] days of the event, **We** will presume that [**You]** [the **Insured Person**] lost [**Your] [**his or her] life as a result of **Injury**. If travel in such conveyance was covered under the terms of the **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that [**You**] [the **Insured Person**] survived the event.

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C4-XX

[**EXTRA-ORDINARY COMMUTATION COVERAGE**

Coverage is extended to include a **Covered Injury** sustained by **You** while commuting directly between **Your** home, and place of regular employment. This can be by car or other conveyance. For this **Coverage** to take effect there must be a stop in service due to a strike or major breakdown of one or more public transit systems **You** regularly use.

This **Coverage** begins when **You** leave **Your** home or place of work. This **Coverage** ends when **You** arrive at **Your** home or place of work. Except for events beyond **Your** control, no losses will be covered if **You** deviate from **Your** normal route.

[This **Coverage** will not be extended if **You** are the operator of a private passenger automobile at the time **You** incur such **Covered Injury**, and **You** are either:

1. under the influence of alcohol;
   - **a.** **You** will be conclusively presumed to be intoxicated if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   - **b.** An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of **Your** intoxication. Or,

2. under the influence of

[a [poison,] [fume,] [noxious chemical substance] that was deliberately ingested][;][or][a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.]]

[a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions.]]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C5-XX]

[**FAMILY TRAVELING WITH EMPLOYEE ON BUSINESS AND/OR RELOCATION TRIPS COVERAGE**

Your Spouse [/**Domestic Partner**] and/or **Dependent Child(ren)** will also be considered a **Primary Insured Person** when they are traveling on a business and/or relocation trip with **You** that is approved by and at the expense of the **Policyholder**. Their coverage will be limited to the **Accidental Death Benefit** [and the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit**] as stated in the **Policy**, when the eligibility for such **Benefit** results from the **Hazards** covered by the **Policy**.

This **Coverage** for **Your Spouse** [/**Domestic Partner**] and/or **Dependent Child(ren)** ends upon arrival at the destination of the **Policyholder's** last reimbursed trip.

The **Principal Sum** for **Your Spouse** [/**Domestic Partner**] and each **Dependent Child** will be as follows:

Spouse [/**Domestic Partner**]:	$[50,000]
Dependent Child(ren):	$[25,000]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C6-XX]

[**FELONIOUS ASSAULT COVERAGE**

Coverage is extended to **You** if **You** sustain a **Covered Injury** as defined under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, as a direct result of a violent or criminal act committed by someone other than **You**, [a **Fellow Employee] [**or a member of **Your Family** or **Household**,] provided:

1. [the **Injury** is incurred in connection with or related to the **Policyholder's** business; and]
2. the **Injury** occurs on the **Policyholder's** premises.

[For purposes of this **Coverage**:

[Fellow Employee means a person employed by the same employer as **You** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than [forty-five (45) days] prior to the date on which the defined violent crime/felonious assault was committed.]

[Family means **Your** parent, stepparent, **Spouse** or former **Spouse**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.]

[Household means a person who maintains residence at the same address as **You**.]

[This **Coverage** applies [only to the crimes or attempted crimes of robbery, theft, holdup, kidnapping.][to any willful or unlawful use of force in connection with the commission of or the attempt to commit a crime including, but not limited to, [robbery,][theft,][kidnapping,][hostage-taking,][assault,][battery,][sniping,][murder,][manslaughter,][riot,] or [insurrection]) that: 1.) results in a covered injury; and 2.) is a felony in the jurisdiction in which it occurs.]]

[For purposes of [on-premises] **Felonious Assault Coverage**, [as well as [on-premises Bomb Scare/Explosion Coverage,] [On-Premises Terrorism Coverage,][War Risk Coverage,]] the **Aggregate Limit of Liability** per **Covered Accident** [combined] is [$0.00].]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C7-XX]

[**HIJACKING** or **SKYJACKING COVERAGE**

The exclusion for war or any acts of war whether declared or undeclared as found in Section VIII General Exclusions of this **Certificate** is modified, and **Covered Injuries** directly resulting from a **Hijacking** or **Skyjacking** or any attempt at any **Hijacking** or **Skyjacking** are covered under the **Policy**.

Hijacking or **Skyjacking** means the unlawful seizure or wrongful exercise of control of an aircraft [or conveyance] or the crew thereof, in which [**You** are] [the **Insured Person** is] traveling as a passenger.

This **Coverage** will continue beyond the actual **Hijacking** or **Skyjacking** while [**You** are] [the **Insured Person** is]:

1. subject to the control of the person(s) making the **Hijacking** or **Skyjacking**; and
2. traveling directly to [**Your**] [the **Insured Person's**] home or original destination.

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C8-XX]

[**ON-PREMISES TERRORISM COVERAGE**

Coverage is extended to **You** if **You** sustain a **Covered Injury** as defined under the **Accidental Death Benefit [**or **Accidental Dismemberment** [**and Covered Loss of Use**][**and Plegia**] **Benefit]** as a direct result of an **Act of Terrorism** while **You** are performing the **Policyholder's** business on the **Policyholder's** premises.

[The benefit for this **On-Premises Terrorism Coverage** will be [15%] of the applicable **Principal Sum** subject to a maximum of [$100,000].]

Act of Terrorism means any intentionally violent or forceful act of any person(s), acting on behalf of an organization or group, with the purpose of creating political turmoil or overthrowing any government.

[For purposes of **On-Premises Terrorism Coverage**, [as well as [[on-premises] Felonious Assault Coverage,] [on-premises Bomb Scare/Explosion Coverage,] [War Risk Coverage,]] the **Aggregate Limit of Liability** per **Covered Accident** [combined] is [$0.00].]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C9-XX]

[**RESERVE CORPS/NATIONAL GUARD UNIT COVERAGE**

If **You** sustain an **Injury**, resulting in a **Covered Loss**, as defined under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, while **You** are a member of an organized **Reserve Corps** or **National Guard Unit** and as such, **You** are:

1. attending any regularly scheduled or routine training of less than [sixty (60)] days, or **You** are enroute to or from such training;
2. attending a **Service School** or **You** are enroute to or from such **Service School**;
3. taking part in any authorized inactive duty training; or,
4. taking part as a unit member in a parade or exhibition authorized by official orders;

You will be eligible to receive the applicable **Principal Sum** for such **Covered Loss**.

[No benefit will be payable for any loss that occurs during active duty.]

For purposes of this **Coverage**, **Service School** means one operated by, or on behalf of, the United States of America or Canada.

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C10-XX]

[**WAR RISK COVERAGE**

The exclusion for war or any acts of war, whether declared or undeclared, as found in Section VIII General Exclusions of this **Certificate** is modified, and **Covered Injuries** directly resulting from war or any acts of war, whether declared or undeclared, are covered under the **Policy**, provided the war or act of war causing the **Injury** does not occur within any of the states of the United States of America (including the District of Columbia) [[or **Your**] [or the **Insured Person**'**s**] country of [residence] [citizenship]] [or the list of countries as on file with the **Policyholder** and **Us**].

[For purposes of **War Risk Coverage** [as well as [on-premises Bomb Scare/Explosion Coverage,] [On-Premises Terrorism Coverage,] [[on-premises] Felonious Assault Coverage,]] the **Aggregate Limit of Liability** per **Covered Accident** [combined] is [$0.00].]

Limitations and Exclusions that apply to this **Coverage** are in Section VII Limitations and Section VIII General Exclusions.

C11-XX]

SECTION V – BENEFITS

ACCIDENTAL DEATH BENEFIT

We will pay the applicable **Principal Sum**, if [**You** sustain] [an **Insured Person** sustains] a loss of life as a result of a **Covered Injury**, and the death occurs within [365] days of the **Covered Injury**.

This benefit is subject to the limitations in Section VII Limitations.

B1-XX

[**ACCIDENTAL DISMEMBERMENT** [**AND LOSS OF USE**] [**AND PLEGIA**] **BENEFIT**

We will pay the benefit amount shown below, if an **Injury** to [**You**] [or **Your Covered Spouse** [/**Domestic Partner**]] [an **Insured Person**] results in any of the following **Covered Losses**, provided the **Covered Loss** occurs within [365] days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person sustaining the **Covered Loss**.

Covered Loss of	**Benefit**
• Both Hands or Both Feet	[**Principal Sum**]

• One Hand and One Foot	[**Principal Sum**]
• One Hand or One Foot plus the loss of Sight of One Eye	[**Principal Sum**]
• Sight of Both Eyes	[**Principal Sum**]
• Speech and Hearing	[**Principal Sum**]
• Speech or Hearing	[50% of **Principal Sum**]
• One Hand; One Foot; or Sight of One Eye	[50% of **Principal Sum**]
• Thumb and Index Finger of the same Hand	[25% of **Principal Sum**]
• [Hearing in One Ear	[25% of **Principal Sum**]]

[A reduced benefit will be payable equal to [50%] of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after [365 days], the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.]

[**Covered Loss of Use** of	**Benefit**
• Four **Limbs**	[**Principal Sum**]
• Three **Limbs**	[75% of **Principal Sum**]
• Two **Limbs**	[66 2/3% of **Principal Sum**]
• One **Limb**	[50% of **Principal Sum**]]

[**Plegia**	**Benefit**
• Quadriplegia (total paralysis of all four **Limbs**)	[**Principal Sum**]
• [Triplegia (total paralysis of three **Limbs**)	[75% of **Principal Sum**]]
• Paraplegia (total paralysis of both lower **Limbs**)	[66 2/3% of **Principal Sum**]
• Hemiplegia (total paralysis of upper and lower **Limbs** on one side of the body)	[50% of **Principal Sum**]
• [Uniplegia (total paralysis of one **Limb**)	[25% of **Principal Sum**]]]

For purposes of this benefit:

- **Covered Loss** means:
  - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
  - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
  - **c.** Total and permanent loss of sight;
  - **d.** Total and permanent loss of speech;
  - **e.** Total and permanent loss of hearing.
- [**Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which [has continued for [12] consecutive months and] is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.]
- [**Plegia** must [continue for [twelve (12)] consecutive months and] be determined by **Our** competent medical authority to be a permanent, complete and irreversible paralysis of [two] or more **Limbs**. A **Limb** means an arm or a leg. Proof of total paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.]

This benefit is subject to the limitations in Section VII Limitations.

[B2-XX][B3-XX][B4-XX]]

[ACCIDENTAL DISMEMBERMENT [AND COVERED LOSS OF USE] [AND PLEGIA] BENEFIT FOR COVERED DEPENDENT CHILDREN

We will pay the benefit shown, if an **Injury** to **Your Covered Dependent Child(ren)** results in any of the following **Covered Losses**, provided the **Covered Loss** occurs within [365] days of the **Accident**:

Covered Loss of	**Percentage** of **Your Principal Sum**
• Both Hands or Both Feet	[50%] to a maximum of $[100,000]
• One Hand and One Foot	[50%] to a maximum of $[100,000]
• One Hand or One Foot plus the loss of Sight of One Eye	[50%] to a maximum of $[100,000]
• Sight of Both Eyes	[50%] to a maximum of $[100,000]
• Speech and Hearing	[50%] to a maximum of $[100,000]
• Speech or Hearing	[25%] to a maximum of $[50,000]
• One Hand; One Foot; or Sight of One Eye	[25%] to a maximum of $[50,000]
• Thumb and Index Finger of the same Hand	[12.5%] to a maximum of $[25,000]
• [Hearing in One Ear	[12.5%] to a maximum of $[25,000]]

[A reduced benefit will be payable equal to [50%] of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after [365 days], the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.]

[**Covered Loss of Use** of	**Percentage** of **Your Principal Sum**
• Four **Limbs**	[50%] to a maximum of $[100,000]
• Three **Limbs**	[37.5%] to a maximum of $[75,000]
• Two **Limbs**	[33%] to a maximum of $[66,000]
• One **Limb**	[25%] to a maximum of $[50,000]]

[**Plegia**	**Percentage** of **Your Principal Sum**
• Quadriplegia (total paralysis of all four **Limbs**)	[50%] to a maximum of $[100,000]
• [Triplegia (total paralysis of three **Limbs**)	[37.5%] to a maximum of $[75,000]]
• Paraplegia (total paralysis of both lower **Limbs**)	[33%] to a maximum of $[66,000]
• Hemiplegia (total paralysis of upper and lower **Limbs** on one side of the body)	[25%] to a maximum of $[50, 000]
• [Uniplegia (total paralysis of one **Limb**)	[12.5%] to a maximum of $[25,000]]]

For purposes of this **Benefit**:

- **Covered Loss** means:
  - **a.** For a foot or hand, actual severance through or above an ankle or wrist joint;
  - **b.** Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
  - **c.** Total and permanent loss of sight;
  - **d.** Total and permanent loss of speech;
  - **e.** Total and permanent loss of hearing.
- [**Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which [has continued for [twelve (12)] consecutive months and] is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.]
- [**Plegia** must [continue for [twelve (12)] consecutive months and] be determined by **Our** competent medical authority to be a permanent, complete and irreversible paralysis of [two (2)] or more **Limbs**. A **Limb** means an arm or a leg. Proof of total paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.]

This benefit is subject to the limitations in Section VII Limitations.

[B5-XX][B6-XX][B7-XX]]

[ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT

We will pay the benefit **s**hown below, if an **Injury** to [**You]** [an **Insured Person**] results in any of the following **Covered Losses**, provided **t**he **Covered Loss** occurs within [365] days of the **Accident**.

The benefit amounts are based on [**Your**] [the **Insured Person's**] **Principal Sum**.

Covered Loss of	**Benefit**
1. Two **Limbs**	[**Principal Sum**]
2. Both hands or all fingers and thumbs of both hands	[**Principal Sum**]
3. Sight of both eyes	[**Principal Sum**]
4. Paralysis of all **Limbs**	[**Principal Sum**]
5. One arm at shoulder	[60% of **Principal Sum**]
6. One arm between shoulder and elbow	[50% of **Principal Sum**]
7. One arm at elbow	[47.5% of **Principal Sum**]
8. One arm between elbow and wrist	[45% of **Principal Sum**]
9. One hand at wrist	[42.5% of **Principal Sum**]
10. Four fingers and thumb of one hand	[42.5% of **Principal Sum**]
11. Four fingers of one hand	[35% of **Principal Sum**]
12. Phalanges of one thumb	[20% of **Principal Sum**]
13. One phalanx of one thumb	[10% of **Principal Sum**]
14. Three phalanges of one index finger	[10% of **Principal Sum**]
15. Two phalanges of one index finger	[8% of **Principal Sum**]
16. One phalanx of one index finger	[4% of **Principal Sum**]
17. Three phalanges of one middle finger	[6% of **Principal Sum**]
18. Two phalanges of one middle finger	[4% of **Principal Sum**]
19. One phalanx of one middle finger	[2% of **Principal Sum**]
20. Three phalanges of one ring finger	[5% of **Principal Sum**]
21. Two phalanges of one ring finger	[4% of **Principal Sum**]
22. One phalanx of one ring finger	[2% of **Principal Sum**]
23. Three phalanges of one little finger	[4% of **Principal Sum**]
24. Two phalanges of one little finger	[3% of **Principal Sum**]
25. One phalanx of one little finger	[2% of **Principal Sum**]
26. First or second metacarpal	[3% of **Principal Sum** each]
27. Third fourth or fifth metacarpal	[2% of **Principal Sum** each]
28. One leg at hip	[50% of **Principal Sum**]
29. One leg between hip and knee	[50% of **Principal Sum**]
30. One leg below the knee	[40% of **Principal Sum**]
31. All toes of one foot	[15% of **Principal Sum**]
32. Both phalanges of one great toe	[5% of **Principal Sum**]
33. One phalanx of one great toe	[2% of **Principal Sum**]
34. Toes other than great toe	[1% of **Principal Sum** each]
35. One eye by removal	[30% of **Principal Sum**]
36. All sight in one eye	[25% of **Principal Sum**]
37. All sight in one eye except for perception of light	[25% of **Principal Sum**]
38. All the lens of one eye	[20% of **Principal Sum**]
39. All hearing in both ears	[40% of **Principal Sum**]
40. All hearing in one ear	[7% of **Principal Sum**]

[A reduced benefit will be payable equal to [50%] of the applicable **Accidental Dismemberment Benefit** for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable **Accidental Dismemberment Benefit** for such dismemberment will be paid if, after

[365] days, the reattachment has failed to the extent that a **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.]

For purposes of this benefit, **Covered Loss** means the actual severance of any member or the total and permanent **Loss of Use** of such member. **Covered Loss of Use** means total paralysis of the member, which is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.

[The benefit for:

1. any and all phalanges of the fingers and thumb of one hand in the aggregate will not exceed the benefit for the **Covered Loss** of four fingers of one hand; and
2. any or all of the phalanges of the fingers of one hand in the aggregate will not exceed the compensation for the **Covered Loss** of four fingers of one hand.]

This benefit is subject to the limitations in Section VII Limitations.

B8-XX]

[**COMA BENEFIT**

We will pay a **Coma Benefit**, if [**You** sustain] [an **Insured Person** sustains] an **Injury** within [365] days of an **Accident**, and such **Injury** causes [**You**] [the **Insured Person**] to be in a **Coma** for at least [thirty-one (31)] consecutive days.

[The **Coma Benefit** is equal to [1%] of [**Your**] [the **Insured Person's**] **Principal Sum**, and will be paid each month [**You** remain] [the **Insured Person** remains] in a **Coma** following the initial [thirty-one (31)] day period. The **Coma Benefit** will end on the earliest of the following:

1. [**You** are] [the **Insured Person** is] no longer in a **Coma** which directly resulted from the **Injury**;
2. [**You** have] [the **Insured Person** has] received a **Coma Benefit** for [100] months.]

[The **Coma Benefit** will be payable at [1%] of [**Your**] [the **Insured Person's**] **Principal Sum** per month for the first [11] months [**You** remain] [the **Insured Person** remains] in a **Coma**, following the initial [thirty-one (31)] day period. At the end of the [11] months of payment, if [**You** remain] [the **Insured Person** remains] in a **Coma**, **We** will pay a lump sum benefit equal to the **Principal Sum** payable under the **Accidental Death Benefit** less the amount of the [11] months of benefit already received.]

Brief periods of consciousness of no more than [one (1) day] in duration will not effect [**Your**] [the **Insured Person's**] eligibility for, or continuation of, benefits.

Coma will be determined by **Our** duly licensed **Physician**.

This benefit is subject to the limitations in Section VII Limitations.

B9-XX]

[**HIV OCCUPATIONAL ACCIDENT BENEFIT**

We will pay an **HIV Benefit**, if **You** sustain an **Injury** resulting in a **Covered Loss** while performing **Your** job related duties, which causes **You** to acquire and test positive within [365 days] of such **Accident** for Human Immunodeficiency Virus (HIV) and/or AIDS and related complex (ARC). Such **HIV Benefit** will be equal to [20%] of **Your Principal Sum** at the date of the **Accident**, but will not exceed [$50,000]. The **HIV Benefit** will be paid in [twenty-four (24)] equal monthly installments.

In order to receive the **HIV Benefit**, **You** must:

1. submit a Workers' Compensation injury report to **Your** employer within forty-eight (48) hours of the **Accident**. If **Your** employer does not maintain Workers' Compensation insurance, **You** must complete an **Accident** report on a form that **We** will provide. The completed **Accident** report must be approved by the **Policyholder** within forty-eight (48) hours of the **Accident** and must be submitted to **Us** within five (5) days of the **Accident**; and
2. submit to a blood test for HIV and/or AIDS and/or related complex (ARC) within forty-eight (48) hours of the **Accident**, which is administered by a duly licensed medical doctor or registered nurse. The blood test results must be sent directly to **Us**.

If the initial test is negative, and **You** subsequently test positive for HIV, AIDS or ARC within [365 days] of the **Accident**, **We** will begin monthly payments on the first of the month following the settlement of the claim.

This benefit is subject to the limitations in Section VII Limitations.

B10-XX]

[**IN-HOSPITAL INDEMNITY BENEFIT**

We will pay:

1. a monthly benefit of [1%] of [**Your**] [the **Insured Person's**] **Principal Sum** to a maximum of [$1,000]; or

2. for periods of less than one (1) month, one thirtieth of the amount calculated in number 1 above, for each complete day of confinement,

if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that requires [**You] [**him or her] to be confined in a **Hospital** for more than [seven (7)] consecutive days.

The initial **Hospital** confinement must begin within [ninety (90)] days of the **Injury** for **[You**] [the **Insured Person**] to be eligible for this benefit.

This benefit will be paid for a maximum of [twelve (12)] months for any **Covered Injury**.

Successive periods of **Hospital** confinement arising out of the same **Injury** will be considered one confinement only if they are separated by a period of less than three (3) months.

The term **Hospital** means a health care facility that meets all of the following requirements:

1. holds a license as a hospital, if required;

2. operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;

3. provides twenty-four (24) hour a day nursing service by registered nurses;

4. has a staff of one or more licensed **Physicians** available at all times;

5. has facilities for diagnosis, and major medical surgical facilities; and

6. is not primarily a clinic, nursing, rest or convalescent home or similar establishment, nor is not, other than incidentally, a substance abuse center or halfway house

This benefit is subject to the limitations in Section VII Limitations.

B11-XX]

[**PERMANENT AND TOTAL DISABILITY BENEFIT**

We will pay a **Permanent and Total Disability Benefit**, if **You** become **Permanently and Totally Disabled** as a result of a **Covered Injury**, provided that **You** become **Permanently and Totally Disabled** within [365] days of the **Injury**; and the **Permanent and Total Disability** continues for [twelve (12)] months. The benefit payable equals **Your Principal Sum** less any amount payable pursuant to the limitations in Section VII Limitations of this **Certificate**.

For purposes of this benefit, **Permanently and Totally Disabled** means that **You** are totally and continually disabled and cannot work, for any income, at any job that he or she is reasonably suited by education, training or experience to do. **Permanent and Total Disability** must be verified by a competent medical authority, and must be expected to continue for the remainder of **Your** life.

[Eligibility for this benefit ends at age [seventy (70)].]

B12-XX]

[PERMANENT AND TOTAL DISABILITY BENEFIT

We will pay a **Permanent and Total Disability Benefit**, if **You** become **Permanently and Totally Disabled** as a result of a **Covered Injury**, provided that **You** become **Permanently and Totally Disabled** within [365] days of the **Injury**; and the **Permanent and Total Disability** continues for [twelve (12)] months.

The monthly amount payable under this benefit will be equal to [1%] of **Your Principal Sum**. These payments will cease at the earlier of the time that:

1. **We** make [100] payments under this provision;

2. **You** are no longer **Permanently and Totally Disabled**;

3. **You** die.

For purposes of this benefit, **Permanently and Totally Disabled** means that **You** are totally and continually disabled and cannot work, for any income, at any job that **You** are reasonably suited by education, training or experience to do. **Permanent and Total Disability** must be verified by a competent medical authority, and must be expected to continue for the remainder of **Your** life.

This benefit is subject to the limitations in Section VII Limitations.

[Eligibility for this benefit ends at age [seventy (70)].]

B13-XX]

SECTION VI – ADDITIONAL BENEFITS

[**ACCIDENT DENTAL EXPENSE BENEFIT**

We will pay an **Accident Dental Expense Benefit**, if [**You** sustain] [an **Insured Person** sustains] a **Covered Injury** which causes [**You]** [him or her] to require treatment for damage to **Sound Natural Teeth**. This benefit will not exceed the **Reasonable and Customary** expenses incurred for the **Medically Necessary** treatment, replacement, or diagnosis of such **Sound Natural Teeth**, provided:

1. the damage to the teeth occurs within [thirty (30)] days of the **Covered Injury**;

2. the expenses are actually incurred and paid within [twenty-six (26)] weeks of the **Covered Injury**; and

3. the services are performed by a licensed dentist or dental surgeon.

The maximum amount payable under this benefit is $[3,000] for any one **Covered Accident**.

We will not cover expenses under this additional benefit for:

1. any expenses covered by Workers' Compensation;

2. any expenses covered by Medicare;

3. any services of a Federal, Veteran's, State or Municipal hospital for which [**You** are] [an **Insured Person** is] not liable for payment;

4. expenses which are more than **Reasonable and Customary**;

5. cosmetic, plastic, or restorative dental treatment unless **Medically Necessary** for the treatment of the **Covered Injury**;

6. the replacement or repair of existing dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, or caps;

7. expenses which [**You** recover] [the **Insured Person** recovers] in a settlement or court judgment;

8. expenses which are covered under any other insurance of any kind;

9. expenses which [**You** are] [the **Insured Person** is] not legally obligated to pay; or

10. expenses that are not **Medically Necessary** for the treatment of the **Covered Injury**.

Medically Necessary means that the dental service or treatment:

1. is essential for the diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed; and

2. meets generally accepted standards of dental practice.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;

2. the degree of professional skill required; and

3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

AB1-XX]

[**ACCIDENT MEDICAL EXPENSE BENEFIT**

We will pay an **Accident Medical Expense Benefit**, if [**You** sustain] [an **Insured Person** sustains] a **Covered Injury**, which causes [**You]** [him or her] to incur medical expenses. This benefit will not exceed the **Reasonable and Customary** expenses incurred by [**You**][the **Insured Person**], in excess of the deductible of [$1,000.00] [and any other valid and collectible insurance], provided that:

1. the first treatment or service occurs within [thirty (30)] days of the **Covered Injury**;

2. the medical expenses are incurred within [365 days] of the **Covered Injury**; and

3. [**You** are] [the **Insured Person** is] under the care and treatment of a **Physician** other than [**Your]** [his or her] spouse, children or any other person who is related to [**You**] [him or her].

The maximum amount payable under this benefit is $[5,000] for any one **Covered Accident**.

We will not cover expenses under this additional benefit for:

1. any **Pre-existing Condition**, until [**You** have] [the **Insured Person** has] been continuously covered under the **Policy** for [twelve (12)] consecutive months;

2. any expenses which are covered by Workers' Compensation;

3. any expenses covered by Medicare;

4. any services of a Federal, Veteran's, State or Municipal hospital for which [**You** are] [an **Insured Person** is] not liable for payment;

5. expenses which are more than the **Reasonable and Customary**;

6. cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Covered Injury**;

7. expenses which [**You** recover] [the **Insured Person** recovers] in a settlement or court judgment;

8. expenses which are covered under any other insurance of any kind;

9. expenses which [**You** are] [the **Insured Person** is] not legally obligated to pay;

10. Custodial Services;

11. expenses that are not **Medically Necessary** for the treatment of the **Covered Injury**.

Custodial Services means any services that are not intended primarily to treat a specific **Injury**. **Custodial Services** include, but will not be limited to, services:

1. related to watching or protecting [**You**] [the **Insured Person**];

2. related to performing or assisting [**You**] [the **Insured Person**] in performing any activities of daily living such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered; and

3. that are not required to be performed by trained or skilled medical personnel.

Medically Necessary means that the medical service or treatment:

1. is essential for the diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed;

2. meets generally accepted standards of medical practice; and

3. is ordered by a **Physician** within the scope of his or her practice.

Pre-existing Condition means a condition for which [**You** have] [the **Insured Person** has] sought or received medical advice or treatment during the [twelve (12)] months immediately preceding [**Your**] [his or her] effective date of **Coverage** under the **Policy**.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;

2. the degree of professional skill required; and

3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

AB2-XX]

[**ACCIDENT WEEKLY INDEMNITY BENEFIT**

We will pay an **Accident Weekly Indemnity Benefit**, if **You** sustain a **Covered Injury**, which renders **You Totally Disabled**, provided:

1. the **Total Disability** occurs within [thirty (30)] days of the date of the **Injury**;
2. **You** have satisfied the **Benefit Waiting Period** of [seven (7)] days; and
3. **You** are being attended to by a duly licensed **Physician**, other than a family member.

Payments will begin on the first day after the benefit **Waiting Period** and will continue for as long as **You** are **Totally Disabled**, but will not exceed the **Benefit Period** of [fifty-two (52)] weeks. The amount of the payments will be equal to [75%] of **Your Base Weekly Earnings** [reduced by] [(1) Workers' Compensation Disability Benefit;] [(2) Social Security Disability Benefits, excluding any amounts for which **Your Dependents** may qualify because of **Your** disability;] [(3) Social Security Retirement Benefits;] [(4) Group Disability Benefits sponsored by the **Policyholder**;] [(5) the amount of any disability income benefits from any automobile or no-fault policy or insurance].

This **Accident Weekly Indemnity Benefit** will not exceed the **Weekly Indemnity Amount** of [$400.00].

Additional Definitions:

- **Base Weekly Earnings** is **Base Annual Earnings** divided by 52.
- **Benefit Period** means the time period, after the end of the benefit **Waiting Period**, that benefits are payable under this benefit subject to any other restrictions or limitations in the **Policy**.
- **Total Disability** (**Totally Disabled**) means that **You** are unable to perform all the substantial and material duties required by his or her regular occupation.
- **Benefit Waiting Period** means the number of consecutive days at the start of a period of continuous **Total Disability** for which **We** will not pay benefits.

AB3-XX]

[**ADDITIONAL DISMEMBERMENT BENEFIT FOR CHILDREN**

We will pay **You** a benefit that will be equal to an additional [100%] of the benefit amount provided by the **Accidental Dismemberment Benefit** that is payable under the **Accidental Dismemberment Benefit**, if **You** select a **Plan** covering **Your** eligible **Dependent Child(ren)**, and **Your Covered Dependent Child** sustains an **Injury** resulting in a **Covered Loss**.

AB4-XX]

[**AFTER SCHOOL CARE BENEFIT**

We will pay an additional benefit for After School Care, if **You** [select a **Plan** covering **Your Dependents** and **You [**or **Your Covered Spouse** [/**Domestic Partner**]]] sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to the individual who incurs the expense on behalf of each [**Covered**] **Dependent Child** if:

1. on the date of the **Accident**, the [**Covered**] **Dependent Child** was enrolled in After School Care, or enrolls in such After School Care within [ninety (90)] days from the date of **Covered Loss**; and
2. the [**Covered**] **Dependent Child** is under age [13].

The **After School Care Benefit** will be equal to the lesser of:

1. the actual cost of the After School Care;
2. [2%] of [**Your Principal Sum] [**the **Principal Sum** of the **Insured Person** who sustained the **Covered Loss]**; or
3. [$2,000].

[If both **You** and **Your Covered Spouse** [/**Domestic Partner**] sustain a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **After School Care Benefit** will be based on **Your Principal Sum**.]

The **After School Care Benefit** will be paid annually for up to [four (4)] consecutive years, if:

1. the [**Covered**] **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the [**Covered**] **Dependent Child** remains enrolled in After School Care.

The After School Care provider may not be a relative or family member and proof, acceptable to **Us** must be provided to establish eligibility for this benefit.

[The maximum amount payable for all eligible [**Covered**] **Dependent Children** under this benefit is [$8,000].]

AB5-XX]

[**CARJACKING BENEFIT**

We will pay an additional benefit equal to [10%] of the applicable **Principal Sum** to a maximum of [$10,000], if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, as a direct result of an **Accident** that occurs during a **Carjacking** of a private passenger automobile that [**You** were] [the **Insured Person** was] operating, getting into or out of, or riding in as a passenger.

Verification of the **Carjacking** must be made part of an official police report within [twenty-four (24)] hours of the **Carjacking** or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within [twenty-four (24)] hours or as soon as reasonably possible, and such verification must be provided to **Us**.

For purposes of this benefit, **Carjacking** means a person other than [**You**] [the **Insured Person**] taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

AB6-XX]

[**COBRA BENEFIT**

We will pay an additional benefit to continue medical insurance for **Your** surviving family members for a period of [one (1) year] from the date of the **Covered Loss**, if **You** [select a **Plan** covering **Your Dependents** and **You**] sustain an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, and **You** are covered under a medical plan sponsored by the **Policyholder**. The amount payable under this benefit will be the lesser of:

1. [5%] of **Your Principal Sum**;
2. [$5,000]; or
3. The actual cost to **Your** surviving family members to continue medical coverage for [one (1) year] under the plan sponsored by the **Policyholder**.

AB7-XX]

[**COMMON CARRIER BENEFIT**

We will pay an additional benefit equal to the lesser of [$50,000] or [50%] of [**Your**] [the **Insured Person's**] **Principal Sum**, if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, provided [**You** sustain][the **Insured Person** sustains] the **Injury** while a passenger riding in or on, boarding, or getting off a **Common Carrier**.

For purposes of this benefit, **Common Carrier** means:

1. any land or water conveyance licensed to carry persons for hire;
2. any civilian aircraft that holds a certificate of Public Convenience and Necessity, a license, or a similar permit for civilian scheduled air carriers issued by the country where the aircraft is registered.

AB8-XX]

[**COMMON DISASTER BENEFIT**

If **You** select a **Plan** covering **Your Dependents** and **You** and **Your Covered Spouse** [**/Domestic Partner**] are both eligible for **Accidental Death Benefits** as a result of **Covered Injuries** sustained in the same **Accident** [and within [ninety (90)] days of such **Accident**,] the **Principal Sum** that would have been payable because of **Your Covered Spouse's** [**/Domestic Partner's**] **Accidental Death Benefit** will be increased to equal that payable for **Your** loss, provided [:

1. **You** and **Your Covered Spouse**[**/Domestic Partner**] are survived by one or more **Covered Dependent Child(ren)**; and
2.]the combined benefits of **You** and **Your Covered Spouse** [**/Domestic Partner**] are not more than [$500,000].

AB9-XX]

[**CONTINUATION OF COVERAGE BENEFIT**

All **Coverages** under the **Policy** that were in force on the date of the indicated **Covered Loss**, with respect to **Insured Persons** other than **You**, will be continued automatically for [365 days] after the date of the **Covered Loss** at no additional cost, if **You** select a **Plan** covering **Your Dependents**, and **You** sustain an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**.

AB10-XX]

[**CRITICAL BURN BENEFIT**

An additional benefit will be payable equal to the lesser of [10%] of the applicable **Principal Sum** or [$10,000], if [**You** are] [an **Insured Person** is] critically burned as a result of a **Covered Accident**, provided all terms and conditions of the **Policy** are met and:

1. [**You** have][the **Insured Person** has] received [third] degree or higher burns over [25%] of [**Your]** [his or her] body; and
2. [**You** have][the **Insured Person** has] undergone reconstructive surgery to treat the burned areas of the body; and
3. the reconstructive surgery has taken place within [365 days] of the occurrence of the **Injury**.

This benefit will not be paid for a critical burn that results from voluntary self-exposure to the sun or to artificial tanning devices.

[If benefits are also payable under the **Reconstructive Surgery Benefit**, only one benefit will be paid, the largest benefit.]

AB11-XX]

[**DAY CARE BENEFIT**

We will pay an additional benefit for Day Care expenses, if **You** [select a **Plan** covering **Your Dependents** and **You [**or **Your Covered Spouse** [/**Domestic Partner**]]] sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to the individual who incurs the expense on behalf of each [**Covered**] **Dependent Child** if:

1. on the date of the **Accident**, the [**Covered**] **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of **Covered Loss**; and
2. the [**Covered**] **Dependent Child** is under age [13].

The **Day Care Benefit** will be equal to the lesser of:

1. the actual cost of the Day Care;
2. [3%] of [**Your Principal Sum]** [the **Principal Sum** of the **Insured Person** who sustained the **Covered Loss]**; or
3. [$3,000].

[If both **You** and **Your Covered Spouse** [/**Domestic Partner**] sustain a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **Day Care Benefit** will be based on **Your Principal Sum**.]

The **Day Care Benefit** will be paid annually for up to [four (4)] consecutive years, if:

1. the [**Covered**] **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the [**Covered**] **Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

An **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

[The maximum amount payable for all eligible [**Covered] Dependent Children** under this benefit is [$12,000].]

AB12-XX]

[**FELONIOUS ASSAULT BENEFIT**

We will pay an additional benefit equal to the lesser of [10%] of **Your Principal Sum** or [$30,000], if **You** sustain an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]** as a result of a violent or criminal act committed by someone other than **You**, [a **Fellow Employee**,**] [**or a member of **Your Family** or **Household**,] provided:

1. the **Injury** is incurred in connection with the **Policyholder's** normal business whether on or off the **Policyholder's** premises[; and
2. the crime directly involves the **Policyholder's** funds or assets].

For purposes of this benefit:

[Fellow Employee means a person employed by the same employer as **You** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than [forty-five (45)] days prior to the date on which the defined violent crime/felonious assault was committed.]

[Family means **Your** parent, stepparent, **Spouse** or former **Spouse**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.]

[Household means a person who maintains residence at the same address as **You**.]

[This benefit applies [only to the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.][to any willful or unlawful use of force in connection with the commission of or the attempt to commit a crime including, but not limited to, [robbery,][theft,][kidnapping,][hostage-taking,][assault,][battery,][sniping,][murder,][manslaughter,][riot,] or [insurrection]) that: 1.) results in a covered injury; and 2.) is a felony in the jurisdiction in which it occurs.]]

AB13-XX]

[FUNERAL EXPENSE BENEFIT

We will pay an additional benefit for **Funeral Expenses** incurred within [thirty (30)] days of the **Covered Loss**, if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**.

The benefit amount will be equal to the lesser of [5%] of [**Your**] **[**the **Insured Person's**] **Principal Sum** or [$5,000].

AB14-XX]

[**HEARING AID OR PROSTHETIC APPLIANCE BENEFIT**

We will pay an additional benefit, if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Benefit**, provided:

1. [**You** are] **[**the **Insured Person** is] required to use a hearing aid or prosthetic appliance;
2. the **Injury** that caused the payment of the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit** is the same **Injury** that requires [**You**] **[**the **Insured Person**] to use the **Hearing Aid or Prosthetic Appliance**; and
3. the **Hearing Aid or Prosthetic Appliance** is required within [365 days] of the **Injury**.

The amount **We** will pay will be equal to the one time cost of the **Hearing Aid or Prosthetic Appliance** actually paid by [**You**] **[**the **Insured Person**].

This benefit will not be paid unless:

1. the **Hearing Aid or Prosthetic Appliance** was prescribed by a legally qualified **Physician** or surgeon who is not **[Your]** [the **Insured Person's**] spouse, child, or relative; and
2. presentation of proof of payment is provided to **Us**.

For purposes of this benefit, **Prosthetic Appliance** will include an artificial limb or eye.

No payment will be made for ordinary living, traveling or clothing expenses.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [10%] of [**Your**] **[**the **Insured Person's**] **Principal Sum** or [$10,000].

AB15-XX]

[**HIGHER EDUCATION BENEFIT**

We will pay an additional benefit for Higher Education expenses, if **You** [select a **Plan** covering **Your Dependents** and **You** [or **Your Covered Spouse**[/**Domestic Partner**]]] sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to the individual who incurs the expense on behalf of each [**Covered**] **Dependent Child** if:

1. on the date of the **Accident**, the [**Covered**] **Dependent Child** was enrolled as a full-time student in an accredited college, university or trade school; or
2. the [**Covered**] **Dependent Child** was at the 12th grade level and enrolls in an accredited college, university or trade school within [one (1)] year from the date of the **Accident**.

The **Higher Education Benefit** will be equal to the lesser of:

1. [5%] of [**Your Principal Sum] [**the **Principal Sum** of the **Insured Person** who sustained the **Covered Loss]**; or
2. [$5,000].

[If both **You** and **Your Covered Spouse** [/**Domestic Partner**] sustain a simultaneous **Covered Loss** which is payable under the **Accidental Death Benefit**, the **Higher Education Benefit** will be based on **Your Principal Sum**.]

The **Higher Education Benefit** will be paid annually for up to [four (4)] consecutive years, if:

1. the [**Covered**] **Dependent Child** continues his or her Higher Education ; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the [**Covered**] **Dependent Child** remains enrolled in an institution of higher learning on a full-time basis.

[The maximum amount payable for all eligible [**Covered] Dependent Children** under this benefit is [$20,000].]

[If, at the time of the **Accident**, a **Plan** covering **Your Dependents** was selected, but there are no [**Covered] Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of [$1,000] to the designated beneficiary.]

AB16-XX]

[**HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT**

We will pay an additional benefit for Home Alterations and/or Vehicle Modifications, if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit**, provided:

1. [**You** are] [the **Insured Person** is] required to use a wheelchair to be ambulatory on a permanent basis;
2. the **Injury** that caused the payment of the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit** is the same **Injury** that requires [**You**] [the **Insured Person**] to need the wheelchair; and
3. the cost is incurred within [365 days] of the **Covered Loss**.

The amount **We** will pay will be equal to:

1. the one time cost of alterations to [**Your**] [the **Insured Person's**] primary residence to make it wheelchair accessible and habitable; and
2. the one time cost of modifications necessary to [**Your**] [his or her] motor vehicle to make the vehicle accessible or drivable.

Benefits will not be payable unless:

1. alterations and/or modifications are made by a person or persons experienced in such alterations and/or modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. presentation of proof of payment is provided to **Us**.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [10%] of [**Your**] [the **Insured Person's**] **Principal Sum** or [$10,000].

AB17-XX]

[**NATURAL DISASTER BENEFIT**

We will pay an additional benefit equal to the lesser of [10%] of [**Your]** [the **Insured Person's**] **Principal Sum** or [$10,000], if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]** as a direct result of a **Natural Disaster**.

For purposes of this benefit, **Natural Disaster** means a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or other similar event.

AB18-XX]

[**PARENT CARE**

We will pay an additional benefit for **Parent Care**, if **You** [or **Your Covered Spouse**[/**Domestic Partner**]] sustain an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**. This benefit will be paid in equal shares to each of **Your Dependent Parents** (or his or her legal guardian) [and the **Dependent Parents** (or his or her legal guardian) of **Your Covered Spouse**[/**Domestic Partner**]].

The amount payable for the **Parent Care Benefit** will be [[$5,000.00] per **Dependent Parent**] [[5%] of **Your** [or **Your Covered Spouse's**[/**Domestic Partner's**]] **Principal Sum]** to a maximum of [$40,000.00] for all **Dependent Parents**. Application for this benefit must be made within [ninety (90)] days of the **Covered Loss**.

For purposes of this benefit, **Dependent Parent** means **Your** parent(s) or grandparent(s) [, or the parent(s) or grandparent(s) of **Your Covered Spouse[/Domestic Partner**]] who, at the time of a **Covered Accident**, is receiving support and care provided by **You** [or **Your Covered Spouse**[/**Domestic Partner**]] as evidenced by the most current tax return filed with the government of the United States of America.

AB19-XX]

[RECONSTRUCTIVE SURGERY BENEFIT

We will pay an additional benefit for **Reconstructive Surgery**, if [**You** sustain**] [**an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit**, provided:

1. the **Reconstructive Surgery** is determined to be medically necessary by a **Physician**; and
2. the **Reconstructive Surgery** has taken place within [365 days] of the occurrence of the **Injury**.

The benefit amount will be in excess of any amounts paid or payable by any other plans and will not exceed the lesser of [5%] of [**Your] [**the **Insured Person's] Principal Sum** or [$5,000].

[If benefits are also payable under the **Critical Burn Benefit**, only one benefit will be paid, the largest benefit.]

AB20-XX]

[**REHABILITATION BENEFIT**

We will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training**, if **You** sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit**. The benefit will be in an amount equal to the lesser of:

1. the actual expenses that are incurred within [two (2)] years from the date of the **Accident** for the **Rehabilitation Training**;
2. [$10,000]; or
3. [10%] of **Your Principal Sum**.

Rehabilitation Training means a treatment program that:

1. is prescribed by a licensed **Physician** acting within the scope of his or her license that is approved by **Us** prior to the provision of services;
2. is required due to **Your Injury**; and
3. prepares **You** for an occupation that **You** would not have engaged in except for the **Injury**.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

AB21-XX]

[SEAT BELT[/AIR BAG] BENEFIT

We will pay an additional benefit [equal to [10%] of the applicable **Principal Sum** up to a maximum] of [$10,000], if [**You** sustain] [an **Insured Person** sustains] an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, provided that [**You** were] [the **Insured Person** was]:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

Verification of [**Your**] [the **Insured Person's**] actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

[An additional benefit [equal to [5%] of [**Your**] [the **Insured Person's**] **Principal Sum** to a maximum] of [$5,000], will be paid if [**You** were] [the **Insured Person** was] driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided [**Your**] [the **Insured Person's**] seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.]

[**We** will not pay a **Seat Belt** [or **Air Bag**] **Benefit** if [**You** are**] [**the **Insured Person** is] the operator of a private passenger automobile at the time [**You** incur] [he or she incurs] such **Covered Injury** and is either:

1. under the influence of alcohol;
   a. [**You**] [An **Insured Person**] will be conclusively presumed to be intoxicated if the level of alcohol in [**Your]** [his or her] blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of [**Your**] [the **Insured Person's**] intoxication. Or,
2. under the influence of

   [a [poison,] [fume,] [noxious chemical substance] that was deliberately ingested][;][or][a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.]]

   [a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions.]]

AB22-XX]

[SPOUSE[/DOMESTIC PARTNER] VOCATIONAL TRAINING BENEFIT

We will pay the actual cost of any professional or trade-training program in which **Your** [**Covered**] **Spouse** [**/Domestic Partner**] enrolls, if **You** [select a **Plan** covering **Your Spouse** [**/Domestic Partner**], and **You**] sustain an **Injury** resulting

in a **Covered Loss** that is payable under the **Accidental Death Benefit**. This benefit will be paid to **Your** [**Covered**] **Spouse** [/**Domestic Partner**], provided:

1. the purpose of the training program is to obtain an independent source of support and maintenance;

2. the actual cost is incurred within [thirty (30)] months from **Your** death; [and

3. the professional or trade training program is licensed by the state.]

The maximum amount payable under this benefit will be [the lesser of [2%] of **Your Principal Sum** or] [$3,000].

AB23-XX]

[**SURVIVOR BENEFIT**

We will pay an additional benefit, if **You** [select a **Plan** covering **Your** [**Dependents**] and **You**,] sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit**. The benefit will be paid to **Your** [**Covered**] **Spouse** [/**Domestic Partner**]. [If there is no eligible [**Covered**] **Spouse**[/**Domestic Partner**], the benefit will be paid in equal shares to **Your** [**Covered**] **Dependent Child(ren)** or their legal guardian.]

The [monthly] benefit will be equal to [1%] of **Your Principal Sum** [and will be paid for a period of [six (6) months] from the date of the **Covered Loss**].

AB24-XX]

[**THERAPEUTIC COUNSELING BENEFIT**

We will reimburse the expenses for **Therapeutic Counseling**, if **You** [select a **Plan** covering **Your Dependents** and **You** or **Your Covered Dependents**] sustain an **Injury** resulting in a **Covered Loss** that is payable under the [**Accidental Death Benefit] [**or] [**Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, and **You** [or **Your Covered Dependents**] require **Therapeutic Counseling**. The benefit will be paid to the individual who incurs the expense, provided:

1. all terms and conditions of the **Policy** are met;

2. **Therapeutic Counseling** begins within [ninety (90)] days of the **Covered Accident**;

3. **Therapeutic Counseling** expenses are incurred within [one (1) year] from the date of the **Covered Loss**.

Therapeutic Counseling means treatment or counseling provided by a licensed therapist or counselor who is registered or certified to provide psychological treatment or counseling.

The maximum amount payable under this benefit is $[1,000.00] for any one **Covered Accident**.

AB25-XX]

[**TERRORISM BENEFIT**

We will pay an additional benefit equal to the lesser of [10%] of [**Your] [**the **Insured Person's] Principal Sum** or [$30,000], if [**You**] [the **Insured Person**] sustain an **Injury** resulting in a **Covered Loss** that is payable under the **Accidental Death Benefit [**or **Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit]**, that was directly caused by an **Act of Terrorism**.

Act of Terrorism means any intentionally violent or forceful act of any person(s), acting on behalf of an organization or group, with the purpose of creating political turmoil or overthrowing any government.

[We may cancel this **Terrorism Benefit** by sending the **Policyholder**, at its most recent address in **Our** records, a [seven (7)] day notice of **Our** intent to cancel. Any unearned premium at the time of a cancellation will be promptly calculated and returned to the **Policyholder** on a pro-rata basis, but the return of the unearned premium is not a condition of cancellation. A change or termination in this benefit will not affect a claim that begins while this benefit is in force.]

AB26-XX]

[**TRAVEL ASSISTANCE**

Travel Assistance will be available to the following **Insured Persons** when they are traveling [[100 miles] or more from their **Principal Residence] [**outside of the U.S.]: [**You** and **Your Spouse** [/**Domestic Partner**] and/or **Child(ren)**, if covered under the **Policy**.] [**You** and **Your Spouse [/Domestic Partner]** and/or **Child(ren)** if **Your Spouse** [/**Domestic**

Partner] and/or **Child(ren)** are with **You** while **You** are covered under the **Policy**. **Your Spouse** [/**Domestic Partner**] and/or **Child(ren)** will not be covered while making a trip without **You**.] The transportation and/or services provided under **Travel Assistance** must be pre-authorized by **Us**. Under the **Policy**, **Travel Assistance** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

Medical Evacuation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care in accordance with **Western Medical Standards**, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**.

For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider. [The maximum amount **We** will pay for this benefit is [$50,000.00].]

[Medical Services
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider duly licensed to provide such services or care in the jurisdiction where the treatment and care are delivered, **We** will pay the lesser of **Our** negotiated rate with such facility or provider, if **We** have a negotiated rate, or the **Reasonable and Customary** expenses incurred by the **Insured Person** [subject to a deductible of $[100.00]], provided that the first treatment or service occurs within [thirty (30)] days of the **Injury** or **Illness**, and the medical expenses are incurred within [365 days] of the **Injury** or onset of **Illness**. **We** must be contacted within [twenty-four (24) hours] of the **Injury** or onset of **Illness** for benefits to be payable.

In addition to exclusions #1 and #2 [and #8] of the TRAVEL ASSISTANCE EXCLUSIONS section below, **We** will not pay for expenses for medical services: 1) that the **Insured Person** is not legally obligated to pay; 2) that are not **Medically Necessary** for the treatment or care of the **Injury** or **Illness**; 3) that are covered by Medicare; [a group health insurance plan sponsored by the **Policyholder**;] [or any other insurance of any kind;] Workers' Compensation, the Defense Base Act, or any other similar Federal or State mandated plan; 4) that are incurred at a Federal, Veterans, State, or Municipal hospital for which the **Insured Person** is not liable; 5) for cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Injury** or **Illness**; 6) for **Custodial Services**; 7) which are more than **Reasonable and Customary**[.][;][8) for any **Pre-Existing Condition** for [365 days] from the earlier of the enrollment or effective date of coverage;][9) for medical treatment or services provided in the United States or its territories.]

For the limited purpose of determining **Our** liability, **We** have the sole right to determine what is **Reasonable and Customary**. [The maximum amount **We** will pay for this benefit is [$5,000.00].]]

Assisted Repatriation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to his or her **Principal Residence**, or to his or her residence in the country where he or she is currently assigned (at his or her option), in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered. [The maximum amount **We** will pay for this benefit is [$25,000.00].]

Post-Recovery Repatriation
If an **Insured Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending **Physician**. The upgrade will be subject to **Our** sole discretion. [The maximum amount **We** will pay for this benefit is [$10,000.00].]

Return of Remains
If an **Insured Person** dies while on a **Covered Trip**, **We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable. [The maximum amount **We** will pay for this benefit is [$5,000.00].]

Visit to Hospital
If an **Insured Person** is scheduled to be hospitalized for more than [seven (7)] consecutive days while on a **Covered Trip**, **We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Insured Person** to visit the **Insured Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable. [The maximum amount **We** will pay for this benefit is [$5,000.00].]

Return of Child
If an **Insured Person** is traveling with a **Child(ren)**, who is under [nineteen (19)] years of age or a **Child(ren)** who prior to age [nineteen (19)] became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Insured Person** for support and maintenance, while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person**, such **Child(ren)** is left unattended, **We** will arrange for, and cover the cost of, the transport of the **Child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Insured Person**, and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Child(ren)** and attendant, if applicable, for benefits to be payable. [The maximum amount **We** will pay for this benefit is [$5,000.00] per **Child** and [$5,000.00] per attendant.]

Return of Companion
If an **Insured Person** is traveling with a companion while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person** the **Insured Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one-way economy class flight. **We** must pre-authorize such costs for benefits to be payable. [The maximum amount **We** will pay for this benefit is [$5,000.00].]

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide **Travel Assistance** if the **Coverage** is excluded under Section VIII General Exclusions of this **Certificate**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from [the deliberate ingestion of a [poison,] [fume,] [noxious chemical substance][;][or][the use of a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.];]

   [the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions];
3. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with **Western Medical Standards**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Insured Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Insured Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or ASSISTED REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
7. **We** did not pre-authorize the transportation and/or services;
8. [the **Injuries** or **Illness** resulted in whole or in part from the **Insured Person** being intoxicated. An **Insured Person** will be conclusively presumed to be intoxicated if, on or about the time of the incident which required medical treatment, the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle. A

report from a law enforcement officer, medical provider or any similar report will be considered proof of the **Insured Person's** intoxication.]

- **[TRAVEL ASSISTANCE LIMITATIONS**

  Aggregate Limit of Liability per Covered Accident
  [$500,000]]

- **TRAVEL ASSISTANCE DEFINITIONS**

  For purposes of **Travel Assistance** only, the following definitions apply:

  Covered Trip means when an **Insured Person** is traveling more than [[100] miles from his or her **Principal Residence]** [outside of the U.S.] and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

  Illness or **Ill** means a sickness or disease which impairs normal functions of the body.

  [Medically Necessary means essential for diagnosis, treatment or care of the **Injury** or **Illness** for which it is prescribed or performed; meets generally accepted standards of medical practice; and is ordered by a medical provider within the scope of his or her license.]

  [Pre-Existing Condition means a condition for which the **Insured Person** has sought or received medical advice or treatment, or for which medical treatment was recommended, during the [six (6)] months immediately preceding the earlier of the enrollment or effective date of coverage under the **Policy**, subject to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and its regulations.]

  Principal Residence means the legal domicile of the **Insured Person**.

  [Reasonable and Customary means the most common charge made by other hospitals, medical facilities, clinics, and medical providers in the same region or area of the world as the treatment or services provided. If the most common expense for a treatment or service can not be determined, **We** will determine Reasonable and Customary based upon: 1) complexity involved; 2) degree of professional skill required; and 3) any other pertinent factors.]

  Western Medical Standards means generally accepted medical standards comparable to those in the United States, [or Canada] [or Western Europe].

  For the purpose of **Travel Assistance**, if there are any differences in the definition of a term between **Travel Assistance** and the **Policy**, the definition in **Travel Assistance** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

  [Right of Recovery
  We have the right to recover any benefits that **We** have paid under **Travel Assistance** if the **Policyholder** or **Insured Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Insured Person** that were covered under **Travel Assistance**. **We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Insured Person** for transportation services and/or expenses, which were not covered under **Travel Assistance**.**]**

  [Excess Coverage
  Our obligation to pay the **Policyholder** or **Insured Person** under **Travel Assistance** will be excess of any other insurance which the **Policyholder** or **Insured Person** has with respect to the expenses covered under **Travel Assistance**.]

  Reservation of Rights
  We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services [or in any country for which a travel warning has been issued by the Department of State of the United States of America].

  [Exempted Countries

Travel Assistance is not available in the following countries: [named countries]. **We** further reserve **Our** rights to modify this list upon [ten (10)] days notice to the **Policyholder**.]

Scope
[Covered transportation expenses will be limited to air and marine conveyance.]

Illness, as covered under **Travel Assistance**, is solely covered under **Travel Assistance**, and in no way supercedes or modifies the other **Coverages** provided under the **Policy**. All other **Coverages** provided under the **Policy** are available only as a result of a **Covered Injury**.

[To contact **Us** regarding **Travel Assistance**, the **Insured Person** must call [1-866-670-6693] from the U.S. or Canada; and collect from anywhere else in the world at [+1-973-630-6693].]

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[**TRAVEL ASSISTANCE REIMBURSEMENT**

Travel Assistance Reimbursement will apply to the following **Insured Persons** when they are traveling [[100 miles] or more from their **Principal Residence]** [outside of the U.S.]: [**You** and **Your Spouse** [/**Domestic Partner**] and/or **Child(ren)**, if covered under the **Policy**.] [**You** and **Your Spouse**[/**Domestic Partner**] and/or **Child(ren)** if **Your Spouse**[/**Domestic Partner**] and/or **Child(ren)** are with **You** while **You** are covered under the **Policy**. **Your Spouse**[/**Domestic Partner**] and/or **Child(ren)** will not be covered while making a trip without **You**.] Under the **Policy**, **Travel Assistance Reimbursement** consists of the following:

- **TRAVEL ASSISTANCE REIMBURSEMENT BENEFITS**

Medical Evacuation
If an **Insured Person** was **Injured** or **Ill** on a **Covered Trip** and had to be transported to a hospital or medical facility which could treat the **Insured Person**'s medical condition in accordance with generally accepted medical standards of the United States of America [or Canada] [or Western Europe], **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** for such transportation, including special personnel and/or equipment. If **We** determine that a closer hospital or medical facility could have provided medical care consistent with the generally accepted medical standards of the United States of America [or Canada] [or Western Europe], **We** will reimburse the **Policyholder** for the expenses which would have been incurred had the **Insured Person** been transported to that hospital or medical facility, if the cost of transportation would have been less than the actual expenses incurred. [In no case will **We** pay more than [$50,000.00].]

Assisted Repatriation
If an **Insured Person** was **Injured** or **Ill** on a **Covered Trip**, and had to be repatriated to his or her **Principal Residence** or to the country where he or she was assigned, **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** for the non-scheduled commercial air flight, or the additional reasonable expenses incurred for the regularly scheduled air flight, including special personnel and/or equipment, if applicable. (Paragraphs [3] and [4] under TRAVEL REIMBURSEMENT EXCLUSIONS will not apply to this benefit.) If **We** determine that alternative transportation could have been provided without compromising the health of the **Insured Person**, **We** will reimburse the **Policyholder** for the reasonable expenses, or additional reasonable expenses, if applicable, which would have been incurred had the alternative transportation been provided to the **Insured Person**, if the cost of such transportation would have been less than the actual expenses incurred. [In no case will **We** pay more than [$25,000.00].]

Post-Recovery Repatriation
If an **Insured Person** was **Injured** or **Ill** on a **Covered Trip**, and had to be repatriated to his or her **Principal Residence**, or to the country where he or she was assigned due to the **Injury** or **Illness**, **We** will reimburse the **Policyholder** for the reasonable additional expenses incurred by the **Policyholder** to change the original travel date on the return flight and/or an upgrade in the seating. [In no case will **We** pay more than [$10,000.00].] (Paragraphs [3] and [4] under TRAVEL ASSISTANCE REIMBURSEMENT EXCLUSIONS will not apply to this benefit.)

Return of Remains
If an **Insured Person** died while on a **Covered Trip**, **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** for local preparation of the body for transport or cremation (not including the cost of

cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. [In no case will **We** pay more than [$5,000.00].]

Visit to Hospital
If an **Insured Person** was scheduled to be hospitalized for more than [seven (7)] consecutive days while on a **Covered Trip**, **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** for the round trip transportation of the person chosen by the **Insured Person** to visit the **Insured Person** while he or she was hospitalized. [In no case, will **We** pay more than [$5,000.00].]

Return of Child
If an **Insured Person** was traveling with a **Child(ren)**, who is under [nineteen (19)] years of age or a **Child(ren)** who prior to age [nineteen (19)] became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Insured Person** for support and maintenance, while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person**, such **Child(ren)** is left unattended, **We** will reimburse the **Policyholder** for the reasonable expenses incurred by the **Policyholder** to transport such **Child(ren**) to the location chosen by the **Insured Person**, including the reasonable expenses incurred for an attendant, if applicable. [In no case will **We** pay more than [$5,000.00] per **Child** and [$5,000] per attendant.]

Return of Companion
If an **Insured Person** was traveling with a companion while on a **Covered Trip**, and due to the **Illness** or **Injury** to the **Insured Person** the **Insured Person** cannot complete the **Covered Trip** as scheduled, **We** will reimburse the **Policyholder** for the additional reasonable expenses incurred by the **Policyholder** to change the travel date of the companion's return flight. [In no case will **We** pay more than [$5,000.00].]

[Access Fee
We will reimburse the **Policyholder** for the expenses the **Policyholder** incurs to provide access to travel assistance services. [In no case will **We** pay more than [$50,000.00].]]

- **TRAVEL ASSISTANCE REIMBURSEMENT EXCLUSIONS**

  We will not reimburse the **Policyholder** for expenses incurred if such expenses would have been excluded as a **Covered Loss** under the **Policy**, or if:

  1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;

  2. the **Injuries** or **Illness** requiring medical services resulted from

  [the deliberate ingestion of a [poison,] [fume,] [noxious chemical substance][;][or][the use of a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.];]

  [the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions];

  3. based upon **Our** review of a claim, **We** determine that the medical care in the hospital, medical facility, or clinic or by the medical provider was and would have been in accordance with generally accepted medical standards of the United States of America [or Canada] [or Western Europe];

  4. based upon **Our** review of a claim, **We** determine that it was not medically necessary to transport the **Insured Person** to another hospital or medical facility.

  5. [the **Injuries** or **Illness** resulted in whole or in part from the **Insured Person** being intoxicated. An **Insured Person** will be conclusively presumed to be intoxicated if, on or about the time of the incident which required medical treatment, the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle. A report from a law enforcement officer, medical provider or any similar report will be considered proof of the **Insured Person's** intoxication.]

- [**TRAVEL ASSISTANCE REIMBURSEMENT LIMITATIONS**

  Aggregate Limit of Liability per Covered Accident
  [$500,000]]

- **TRAVEL ASSISTANCE REIMBURSEMENT DEFINITIONS**

For purposes of **Travel Assistance Reimbursement** only, the following definitions apply:

Covered Trip means when an **Insured Person** is traveling more than [[100] miles from his or her **Principal Residence]** [outside of the U.S.] and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE REIMBURSEMENT EXCLUSIONS set forth above.

Illness or **Ill** means a sickness or disease, which impairs normal functions of the body.

Principal Residence means the legal domicile of the **Insured Person**.

- **TRAVEL ASSISTANCE REIMBURSEMENT - OTHER PROVISIONS**

[**Excess Coverage**
Our obligation to reimburse the **Policyholder** under **Travel Assistance Reimbursement** will be excess of any other insurance which the **Policyholder** or **Insured Person** has with respect to the expenses covered under **Travel Assistance Reimbursement**.]

[Right of Recovery
We have the right to recover any benefits, which **We** have paid to the **Policyholder** under **Travel Assistance Reimbursement**, if the **Policyholder** recovers any money from a third party for the expenses incurred by the **Policyholder** that were covered under **Travel Assistance Reimbursement**. **We** will be reimbursed from such recovery, and **We** will have a lien against that recovery.]

Scope
[Covered transportation expenses will be limited to air and marine conveyances.]

Illness, as covered under **Travel Assistance Reimbursement**, is solely covered under **Travel Assistance Reimbursement**, and in no way supercedes or modifies the other **Coverages** provided under the **Policy**. All other **Coverages** provided under the **Policy** are available only as a result of a **Covered Injury**.

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SECTION VII – LIMITATIONS

Limitation on Multiple Covered Losses.

We will pay only one benefit, the largest benefit, if [**You** sustain] [an **Insured Person** sustains] more than one loss as a result of the same **Accident**.

Limitation on Multiple Benefits.

The most **We** will pay for the following benefits, in total, is [**Your**] [the **Insured Person's**] **Principal Sum**, if [**You]** [the **Insured Person**] can recover benefits under more than one of these: **Accidental Death Benefit**, [**Accidental Dismemberment** [**and Covered Loss of Use**] [**and Plegia**] **Benefit**,**]** [**Coma Benefit**,] [**Permanent and Total Disability Benefit**,] [**HIV Occupational Accident Benefit**,] [**In-Hospital Indemnity Benefit**] as a result of the same **Accident**.

Limitation on Multiple Hazards.

We will pay only one benefit, the largest benefit [unless there is a specific written exception in the **Policy**], if [**You** sustain] [**an Insured Person** sustains] a **Covered Loss** that is covered under more than one **Hazard**.

[**Aggregate Limit**.

We will not pay more than the **Aggregate Limit of Liability** stated in the Schedule.]

SECTION VIII – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

- [suicide or any attempt at suicide [or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury[**with regard to **Accidental Dismemberment [and Loss of Use][and Plegia] Benefits** only**]]** [including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of autoeroticism or auto-erotic asphyxiation];]
- [war or any act of war, whether declared or undeclared [occurring in the following geographic locations [named countries] only];]
- [involvement in any type of active military service[.] [(Reserve or National Guard active duty training is not excluded, unless it extends beyond [thirty-one (31) consecutive days].)] [(For purposes of this exclusion, orders to active military service for [sixty (60) days] or less will not be considered involvement in active military service.)] [(This exclusion does not apply to the first [sixty (60) consecutive days] of active military service.)];]
- illness or disease [, regardless of how contracted,] ; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; [except for **Accidental** ingestion of contaminated foods];
- [participation in the commission or attempted commission of [a crime,] [any felony,] [an assault,] [insurrection] [or] [riot];]
- [[parasailing,] [bungee jumping,] [heli-skiing,] [scuba diving] [or any other extra-hazardous activity];]
- [[being intoxicated while operating a motor vehicle.]

  [being intoxicated.]

  1. [A **Primary Insured Person**] [An **Insured Person**] will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.

  2. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the [**Primary Insured Person's**] [**Insured Person's**] intoxication.]
- [[the deliberate ingestion of a [poison,] [fume,] [noxious chemical substance][;][or][the use of a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.];]

  [the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions.];]
- [travel or flight in any aircraft except to the extent stated in the **Hazards** Section;]
- [a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**;]
- [alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a **Physician** operating within his or her scope of authority.]

SECTION IX – CLAIMS PROVISIONS

Notice. You or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within twenty (20) days of such **Covered Loss**. The notice must name **You**, the **Insured Person** who sustained the **Injury**, and the **Policy** Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at [866-583-2233.] The notice must be sent to the Claims Department, Atlantic Specialty Insurance Company, [P.O. Box 1009, Morristown, NJ 07962-1009], or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

Claim Forms. We will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss**.

Proof of Covered Loss. Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss**, and the proof was provided as soon as reasonably possible.

Time of Payment. We will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.

Recipient of Payment.

1. **Your** Loss of Life. **Covered Losses** resulting from **Your** death are paid to **Your** named beneficiary at the time of death. If there is no beneficiary named or **Your** named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to [the beneficiary **You** named for the **Policyholder's** Group Life Insurance policy. If there is no beneficiary named for **Your Policyholder's** Group Life Insurance policy, or **Your** named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to] [**Your** survivors in the following order:
   a. **Your Spouse**[or **Domestic Partner**];
   b. **Your** child(ren);
   c. **Your** parents;
   d. **Your** brothers and sisters;
   e.] **Your** estate.
2. [**Your Covered Dependent's** Loss of Life. **Covered Losses** for the death of **Your Covered Dependent** will be paid to **You**. If **You** pre-decease or die at the same time as **Your Covered Dependent**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to **Your** estate.
3.] All Other Claims. Benefits are to be paid to [**You]** [the **Insured Person**]. [[**You]** [He or she] may direct in writing that all, or part of the **Accident Medical Expense Benefit**, if applicable, will be paid directly to the party who furnished the service. The direction may be changed by [**You**] [the **Insured Person**] at any time up to the filing of the proof of **Covered Loss**.]
[4. If a **Foreign National** is entitled to benefits for a **Covered Loss** and **We** are unable to make payment directly to him or her because of legal restrictions in the country or jurisdiction where such **Foreign National** is located, **We** will either: (1) pay the benefits to a bank account owned by the **Foreign National** in the United States of America; or (2) if no such bank account is established or maintained, **We** will pay the benefits to the **Policyholder** on behalf of the **Foreign National**. It will then be the responsibility of the **Policyholder** to remit the benefit to such **Foreign National**. Payment of the benefit to the **Policyholder** will release **Us** from any further liability to the **Foreign National**. If the **Policyholder** does not remit the payment to the **Foreign National**, the **Policyholder** will indemnify **Us** and hold **Us** harmless against any and all liability incurred by **Us** including, but not limited to, interest, penalties, and attorneys' fees in connection with, arising or resulting from such failure to remit payment. The **Policyholder** will not be considered the beneficiary under the **Policy** if payment is made to the **Policyholder** in accordance with this provision.]

Physical Examination and Autopsy. We have the right to examine [**You**] [the **Insured Person**] when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

Choice of Service Provider. [**You** have] [The **Insured Person** has] the sole right to choose [**Your**] [his or her] duly licensed **Physician** and hospital.

[**Right to Recover Overpayments**. In addition to any rights of recovery or reimbursement provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** will have the right to recover such excess

payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to the **Insured Person** (and his or her assignee) under the **Policy** to the extent of the overpayment.]

Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina, Wisconsin and Alabama) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where [**You** live] [the **Insured Person** lives] makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

[**Arbitration.** Any contest to a claim denial under the **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to [**You**] [the **Insured Person**]. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if [**You** are] [the **Insured Person** is] a resident of a state where the law does not allow binding arbitration in an insurance **Policy**, but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of lawsuit by [**You]** [the **Insured Person**].]

SECTION X – GENERAL PROVISIONS

Beneficiaries. You have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. **You** may change the beneficiary at any time unless **You** have assigned the interest in the **Policy**. In such case, the person to whom **You** have assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us**.

Change or Waiver. A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

Clerical Error. A clerical error or omission will not increase or continue **Your Coverage**, which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

Conformity with Statute. Terms of the **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.

[**Assignment of Interest.** A transfer of interest is binding when **We** receive written notice on a form acceptable to **Us**. **We** have no duty to confirm that a transfer is valid.]

[Incontestability. The validity of the **Policy** will not be contested after it has been in force for two (2) years from the **Policy** Effective Date, except as to nonpayment of premiums.]

SECTION XI – DEFINITIONS

- **Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.

- **Active** or **Actively at Work** describes an employee who is able and available for active performance of all of his or her regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered actively at work provided the employee is able and available for active performance of all of his or her regular duties and was working the day immediately prior to the date of his or her absence.

- **[Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the **Policy**. For purposes of the Aggregate Limit of Liability provision, **Covered Accident** or **Covered**

  Accidents will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause [occurring within a [one (1)] day period] and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each **Insured Person**, **We** will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.]

- [**Chartered Aircraft** means an aircraft operated by a company with an air carrier or commercial operating certificate issued by the Federal Aviation Administration or the equivalent certificate issued by a foreign government, which the **Policyholder** has the right to use for no more than [ten (10)] consecutive days and/or for no more than [fifteen (15)] days in a [one (1)] year period.]

- [**Controlled** by, as used in the **Hazards** Section, means the **Policyholder** has the right to use a block of aircraft flight time for [25] or more hours in a [one (1)] year period or for [100] hours or more without a specified term, from a company which is in the business of providing aircraft for private use. A **Chartered Aircraft** will not be considered **Controlled** by the **Policyholder**.]

- **Coverage(s)** means the event or events described in the **Hazards** Section **[**and Additional Coverages Section] of this **Certificate** to which benefits and additional benefits apply. The **Hazards** [and Additional Coverages] are listed in the Schedule.

- **Covered Accident** means an **Accident** that results in a **Covered Loss**.

- **Covered Injury** means an **Injury** directly caused by an **Accident**, which is independent of all other causes, results from a **Covered Accident**, occurs while the **Insured Person** is insured under the **Policy**, and results in a **Covered Loss**.

- **Covered Loss** means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury**, and for which benefits are payable under the **Policy**.

- **Dependent** means **Your Spouse** [/**Domestic Partner**] and **Dependent Child(ren)**, as defined in this Section. [The **Dependent** will only be a **Covered Dependent** if **You** select a **Plan** covering **Your Dependents**.]

- **Dependent Child(ren)**, if used in this **Certificate**, means **Your** unmarried **Child(ren)**, [and] [those unmarried **Child(ren)** of **Your Spouse]** [, and those unmarried **Child(ren)** of **Your Domestic Partner** [as defined in the **Policyholder's** [medical] plan as on file with and approved by **Us**]] who rely on **You** for [more than 50% of] their support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap. [**Dependent Child(ren)** will only be **Covered Dependent Child(ren)** if **You** select a **Plan** covering **Your Dependent Child(ren)**.]

- [**Domestic Partner** means [a person who qualifies as a domestic partner under the **Policyholder's** written procedures as on file with and approved by **Us**.] [a person who qualifies as a domestic partner under the law of the state of residence.] [a person as defined in the **Policyholder's** [medical] plan as on file with and approved by **Us**.]]

- [**Domestic Partner**
  To qualify as a domestic partner, the following requirements must be met:
  1. [**You** and **Your** domestic partner must have an intimate, committed relationship of mutual caring, and have agreed to be responsible for each other's welfare;]
  2. [**You** and **Your** domestic partner must have lived together in such a relationship for a period of not less than six consecutive months at the same residence address;]
  3. [**You** and **Your** domestic partner must both be at least 18 years of age;]
  4. [neither **You** nor **Your** domestic partner are legally married;]
  5. [**You** and **Your** domestic partner are not related by blood or adoption;]

6. [**You** and **Your** domestic partner are each other's sole domestic partner and intend to remain so indefinitely; and]

7. [**You** and **Your** domestic partner must be of the same sex, and if applicable law permitted, would be married.]

The existence of the relationship between **You** and **Your** domestic partner must be evidenced by:

1. [**Your** domestic partner being named as the primary beneficiary in the event of **Your** death under **Your** retirement plan or 401(k) plan, if **You** maintain such a plan;]

2. [at least one of the following:

a. designation of **Your** domestic partner as a primary beneficiary under **Your** will; or

b. designation of **Your** domestic partner as a primary beneficiary for **Your** life insurance;]

3. [at least one of the following:

a. joint ownership of real estate (whether by mortgage, lease or deed);

b. joint ownership of a motor vehicle; or

c. joint ownership of a bank account; and]

4. [a completed, active certification of domestic partner status form on file with the **Policyholder**.]

To have coverage, **You** will not have completed a Termination of Domestic Partner status form with respect to **Your** domestic partner who is to be covered under the **Policy**.]

- [**Foreign National** means a person who is a citizen of a country or jurisdiction other than the United States of America and who is not a resident of the United States of America.]
- **Injured**, **Injury or Injuries** means bodily harm or bodily damage.
- **Insured Person** means any person who has insurance under the terms of the **Policy**. It includes **You** [, and **Your Spouse** [**/Domestic Partner**] and/or **Dependent Child(ren)** if **You** select a **Plan** covering **Your Spouse** [**/Domestic Partner**] and/or **Dependent Child(ren)]**.
- [**Owned Aircraft** means an aircraft in which the **Policyholder** [or a related company] has legal or equitable title. Fractional ownership in a company which is in the business of providing aircraft for private use will be deemed to be equitable title in the aircraft used by the **Policyholder**.]
- **Physician** means a person who is licensed to practice medicine in the jurisdiction in which the medical service or treatment is performed and is acting within the scope of his or her license.
- **Plan** means the plan design as described in the Schedule.
- **Policy** means the Group **Accident** Insurance **Policy**.
- **Policyholder** means the group named on the front page of the **Policy**.
- **Primary Insured Person** means an individual who [has an employment relationship with the **Policyholder**;] is eligible for coverage under the **Policy** as provided in the Eligibility of **Primary Insured Persons** part of Section I[; and who completes the enrollment material].
- [**Service Waiting Period** means the continuous length of time a person is required to be employed by the **Policyholder** prior to being covered under the **Policy**.]
- **[Specialized Aviation Activity** means an aircraft while it is being used for one or more of the following activities:

[acrobatic or stunt flying]
[aerial photography]
[banner towing]
[bird or fowl herding]
[crop dusting]
[crop seeding]
[crop spraying]
[endurance tests]
[exploration]
[fire fighting]
[flight on a rocket-propelled or rocket launched aircraft]
[hanggliding]
[hunting]
[parachuting or skydiving]
[pipe line inspection]
[power line inspection]
[racing]
[skywriting]
[test or experimental purpose]]

[flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted]

- **Spouse**, if used in this **Certificate**, means **Your** legally married **Spouse** [under age 70]. [**Your Spouse** will only be a **Covered Spouse** if **You** select a **Plan** covering **Your** eligible **Spouse**.]
- [**Under lease**, as used in the **Hazards** Section, means an aircraft which the **Policyholder** does not own but has the right to use, under a written agreement, for more than [ten (10)] consecutive days and/or for more than [fifteen (15)] days in a [one (1)] year period. A **Chartered Aircraft** will not be considered **Under lease**.]
- **We**, **Us** and **Our** refers to Atlantic Specialty Insurance Company.
- **You** and **Your** refers to the **Primary Insured Person**.

In Witness Whereof, We have caused the Policy to be executed and attested, and, if required by state law, the Policy shall not be valid unless countersigned by Our authorized representative.

Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company

Michael Miller, President & CEO
Atlantic Specialty Insurance Company

Countersigned _____
Authorized Representative Date

INSURANCE BINDER

CONDITIONS

This **Binder** is a temporary insurance contract. This insurance is subject to the terms, conditions and limitations of the **Policy(ies)** in current use by the **Company**. This **Binder** may be cancelled by the **Policyholder** by surrendering this **Binder** or providing written notice to the **Company** stating when cancellation will be effective. This **Binder** may be cancelled by the **Company** in accordance with the **Policy** provisions by providing notice to the **Policyholder**. This **Binder** is automatically cancelled when the **Company** issues a **Policy** which substantially meets the benefits outlined in this **Binder**. If the **Policyholder** does not replace this **Binder** with a **Policy**, the **Company** is entitled to charge a premium for the **Binder** according to the Rates and Rules in use by the **Company**.

COMPANY: **Atlantic Specialty Insurance Company** (also referred to as the **Company)**

POLICYHOLDER NAME: _____

POLICYHOLDER ADDRESS: _____

EFFECTIVE DATE OF BINDER: _____

EXPIRATION DATE OF BINDER: _____

Description of **Coverage:**

Eligibility:

Benefits Provided:

Applicable **Principal Sum:**

This **Binder** is issued to the **Policyholder** in consideration of a premium in the amount of $_____, which is due within [sixty (60)] days of the receipt of the **Binder**.

The **Company** will accept the most current enrollment, application, coverage and/or benefit election, beneficiary designation, and assignment forms on file with the **Policyholder** as of the **Effective Date** of this **Binder**.

Signed for Atlantic Specialty Insurance Company by: _____

Date:_____

Signed for **Policyholder** by: _____

Date:_____

Policyholder: [ABC Company] Effective Date of Endorsement: [January 1, 2007]

Policy Number: [1234567]

DESCRIPTION OF HAZARDS ENDORSEMENT

This **Policy** insures against the following **Hazards**:

Except for the above, this Endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested, and, if required by state law, this Endorsement shall not be valid unless countersigned by our authorized representative.

Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company

Michael Miller, President & CEO
Atlantic Specialty Insurance Company

Policyholder: [ABC Company] Effective Date of Endorsement: [January 1, 2007]

Policy Number: [1234567]

PREMIUM REFUND ENDORSEMENT

If during the course of the **Policy** year there are no payable claims[*] filed against this **Policy**, **We** will return [20%] of the annual premium as stated in the Premium section of this **Policy** to the **Policyholder**. **We** will review the claims at the beginning of the seventh month following the end of the **Policy** year period to determine if the **Premium Refund** is payable. The review will be done at that time to allow **Us** to confirm that any claim for the **Policy** year period has been submitted for payment. This will address the lag in reporting that can occur for claims that are incurred late in the **Policy** year.

Note: The amount returned will be net of commissions, if applicable.

[* Travel Assistance claims will not be charged against the experience to calculate the **Premium Refund.**]

Except for the above, this Endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested, and, if required by state law, this Endorsement shall not be valid unless countersigned by our authorized representative.

Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company

Michael Miller, President & CEO
Atlantic Specialty Insurance Company

Policyholder: [ABC Company] Effective Date of Endorsement: [January 1, 2007]

Policy Number: [1234567]

EXTENSION OF WAR RISK COVERAGE ENDORSEMENT

It is hereby understood and agreed that, in consideration of the payment of additional premium of [$4,000], War Risk Coverage will be extended as follows:

Insured Person	**Travel Dates**	**Country**	**Principal Sum**	[**Additional Premium**]
[Jane Dolan]	[March 10, 2007 through April 10, 2007]	[Iran]	[$150,000]	[$3,900]

Except for the above, this Endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested, and, if required by state law, this Endorsement shall not be valid unless countersigned by our authorized representative.

Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company

Michael Miller, President & CEO
Atlantic Specialty Insurance Company

PORTABILITY COVERAGE
CERTIFICATE ENDORSEMENT

Policyholder: [_____] **Policy** Number:[_____]

This **Certificate** Endorsement should be attached to and made part of the **Certificate of Insurance** belonging to the **Certificate** holder indicated below for the above **Policy**.

Certificate holder: [_____]
Address: [_____
_____]

Certificate Endorsement Number: [_____]

[Initial **Portability Coverage** Period: From:[_____] to:[_____]

This **Certificate** Endorsement is issued in consideration of an initial annual premium of $[_____]]

[Renewal Period for **Portability Coverage**: From:[_____] to:[_____]

This **Portability Coverage Renewal Certificate Endorsement** is issued in consideration of a 12-month renewal premium of $[_____].

The renewal premium is based upon the rates that are determined to be appropriate at the time of renewal.]

[Insurance, as provided in the referenced **Policy**, is also ported for **Your Covered Dependents** provided they had **Coverage** under this **Policy** at the time of **Your** application for **Portability Coverage**.]

We agree to provide Insurance, as stated below, for loss resulting from an **Accidental Injury** covered under the referenced **Policy**. The benefit amount payable, and any qualifications, is listed next to the Benefit. The Benefit, to the extent provided, will be paid subject to all the terms of the **Policy**.

SCHEDULE OF INSURANCE

HAZARDS:

The following are the **Hazards** for which Insurance applies:

[24 Hour **Accident** Protection, Business and Pleasure: Coverage as stated in the **Policy**]

[ ]

ADDITIONAL COVERAGES:

Exposure and Disappearance Coverage: Coverage as stated in the **Policy**
[ ]

BENEFITS:

Accidental Death Benefit: 100% of **Your Principal Sum** which is equal to [$100,000][the amount stated in the **Policy]**
[Principal Sum for **Your Covered Dependents** is calculated as stated in the **Policy]**

[Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Benefit: Benefit is based on the percentage of **Your Principal Sum** payable for the specific **Covered Loss [Covered Loss of Use] [Plegia]**, as stated in the **Policy**.]
[Benefit for **Your Covered Dependents** is based on the percentage of **Your Covered Dependent's Principal Sum** payable for the specific **Covered Loss [Covered Loss of Use] [Plegia]**, as stated in the **Policy**, for him or her.]]

[ ]

[ADDITIONAL BENEFITS:

[Seat Belt Benefit: Benefit as stated in the **Policy**]

[Rehabilitation Benefit: Benefit as stated in the **Policy**]

[ ]]

LIMITATIONS:

[Aggregate Limit of Liability: [$1,000,000] per [air travel] **Covered Accident**.]

[ ]

EXCLUSIONS:

- [suicide or any attempt at suicide [or intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**]]
- [war or any act of war, whether declared or undeclared]
- illness or disease [,regardless of how contracted,]; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; [except for **Accidental** ingestion of contaminated foods
- [ ]

[Except for [non-payment of premium or] reaching the age of [70], [or cancellation of the **Policy**,] **You** have the right to continue **Portability Coverage** under this **Policy** [, even if this **Policy** is canceled].]

Nothing contained herein shall be held to waive or extend any provisions and other terms of the **Policy** or **Certificate of Insurance** to which this **Certificate** Endorsement is made a part, except as provided above.

This document is a summary of **Your** benefits under the **Policy** indicated above. For detailed information about **Your** benefits, please see the **Policy**. If there is any discrepancy between this summary and the actual contents of the indicated **Policy**, the **Policy** will govern.

In Witness Whereof, We have caused this Endorsement to be executed and attested, and, if required by state law, this Endorsement shall not be valid unless countersigned by our authorized representative.

Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company

Michael Miller, President & CEO
Atlantic Specialty Insurance Company

Policyholder: [ABC Company] Effective Date of Endorsement: [January 1, 2007]

Policy Number: [1234567]

ADMINISTRATIVE CHANGE ENDORSEMENT

[This endorsement will be used to make the following changes to the **Policy**:

Addition or deletion of a subsidiary or affiliate
Name change of **Policyholder**
Address change of **Policyholder**
Changes to the Schedule page, e.g. change in coverage upon **Policyholder** request such as adding or deleting a benefit, increasing or decreasing amount of coverage
Renewal
Other administrative changes]

Except for the above, this Endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested, and, if required by state law, this Endorsement shall not be valid unless countersigned by our authorized representative.

Dennis R. Smith, Secretary
Atlantic Specialty Insurance Company

Michael Miller, President & CEO
Atlantic Specialty Insurance Company

SERFF Tracking Number:	*CLTR-127669531*	*State:*	*Arkansas*
Filing Company:	*Atlantic Specialty Insurance Company*	*State Tracking Number:*	*49949*
Company Tracking Number:	*AH 100A ADD AR F*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*AD&D*		
Project Name/Number:	*Group AD&D Filing/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	10/06/2011

Comments:

Attachment:

CW Readability Cert.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	10/06/2011

Comments:

Attachment:

PolicyHolder-Group ACC Application.pdf

		Item Status:	Status Date:
Satisfied - Item:	Authorization	Approved	10/06/2011

Comments:

Attachment:

ASIC Authorization to File.pdf

		Item Status:	Status Date:
Satisfied - Item:	Certification	Approved	10/06/2011

Comments:

Attachment:

Rule and Regulation 19 Certification.pdf

READABILITY CERTIFICATION

This is to certify that the form(s) below has (have) been subject to the Flesch Reading Ease Test.

A. Option Selected

_____ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.

__X__ 2. Policy and riders are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:

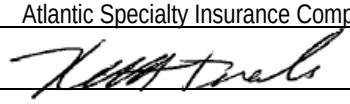
Form	Form Number	Flesch
Group Policy	AH 100A GA CW 08 11	45.8
Certificate of Insurance	AH-102A GA CW 08 11	45.3
Insurance Binder Agreement	AH 105A GA CW 08 11	45.7
Administrative Changes Rider	AH 106A GA CW 08 11	45.5
Description of Hazards Endorsement	AH 107A GA CW 08 11	44.2
Premium Refund Endorsement	AH 108A GA CW 08 11	50.0
Extension of War Risk Coverage End.	AH 109A GA CW 08 11	44.2
Portability Endorsement	AH 110A GA CW 08 11	46.3

B. Test Option Selected

__X__ 1. Test was applied to entire form(s).

_____ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of forms enclosed indicating word samples tested.

Company Name: Atlantic Specialty Insurance Company

Signature of Certifying Official: 

Printed Name and Title of Certifying Official: Keith Firestone, Assistant Secretary

Certifying Official's Address: 1 Beacon Lane, Canton MA 02021-1030

Date Signed: September 29, 2011

POLICYHOLDER APPLICATION

GROUP [VOLUNTARY] [BASIC] [BUSINESS TRAVEL] ACCIDENT INSURANCE

Policy Effective Date: _____

- **POLICYHOLDER INFORMATION**

Name: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Subsidiaries to be covered: _____

_____

Contact Person: _____ Title: _____

Telephone: _____ Fax: _____

- **PRODUCER INFORMATION**

Agent/Broker: _____ Name of Firm: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Producer Number: _____ Commission: _____

- **INSURANCE REQUESTED**

A. CLASS(ES) OF PRIMARY INSURED PERSONS **[TOTAL NUMBER OF EMPLOYEES]**

Class 1: [All active employees of the Policyholder working a minimum of [30] hours per week] _____

[Class 2: [All active Union employees of the Policyholder] _____

[Class 3: [ ]] _____

[☐ Full-time Drivers Included ☐ Yes ☐ No _____

[☐ Foreign Nationals Included ☐ Yes ☐ No _____

[☐ Spouse Coverage ☐ Yes ☐ No]

[☐ Domestic Partner Coverage ☐ Yes ☐ No]

[☐ Dependent Child(ren) Coverage ☐ Yes ☐ No]

[**Travel Data**

- Number of employees who travel 50+ days per year:

  Class 1: _____

  [Class 2: _____]

[Class 3:_____]

- Number of employees who travel more than 25 and less than 50 days per year:

  Class 1: _____
  [Class 2: _____]
  [Class 3: _____]

- Number of employees who travel less than 25 days per year:

  Class 1: _____
  [Class 2: _____]
  [Class 3: _____]

- Number of employees who do not travel:

  Class 1: _____
  [Class 2: _____]
  [Class 3: _____]]

[**Service Waiting Period**

Eligible individuals hired prior to the Policy Effective Date: _____

Eligible individuals hired on or after the Policy Effective Date: _____]

B. PRINCIPAL SUM

[Class 1] [An employee may purchase an amount of Principal Sum from a minimum of [$50,000] to a maximum of [$500,000] in increments of [$10,000]. [However, amounts applied for in excess of [$150,000] must not exceed [ten (10)] times the employee's Base Annual Earnings*.]]

[Class 2] [[Three (3)] times the employee's Base Annual Earnings* to a maximum of [$500,000].]]

[Class 3] [$100,000]]

[*Base Annual Earnings means the employee's base annual pay [excluding overtime, bonuses, [commissions] and special compensation.]]

[The Principal Sum for Covered Dependents will be a percentage of the employee's Principal Sum:

Plan Selected	**% Spouse[/Domestic Partner]**	**% Child(ren)**
Spouse[/Domestic Partner] only:	[50%]	0
Dependent Child(ren) only:	0	[15%]
Spouse[/Domestic Partner] and Dependent Child(ren)	[40%]	[10%]

[Maximum of [$25,000] [Principal Sum] [Accidental Death Benefit] for Dependent Child(ren).]

[For Covered Dependent Child(ren) the indicated percentage applies to loss of life only.]

[In no event will the amount be greater than the Primary Insured Person's Principal Sum.]]

[The Principal Sum for Covered Dependents will be [a choice of] the following amounts:

Spouse[/Domestic Partner]: [$50,000] [$75,000] [$100,000]

Dependent Child(ren): [$10,000] [$15,000] [$20,000] [$25,000]

[In no event will the amount be greater than the Primary Insured Person's Principal Sum.]]

[Principal Sum Reduction

[At age [70], [for the Primary Insured Person only,] the Principal Sum will be reduced based on the [Primary Insured Person's] [Insured Person's] previous Principal Sum per the following schedule:

Age at Date of Loss	Percent of Principal Sum
[70-74]	[65%]
[75-79]	[45%]
[80-84]	[30%]
[85 & Over]	[15%]]

Aggregate Limit of Liability

[The Aggregate Limit of Liability per [air travel] Covered Accident is [$0.00].]

[The Aggregate Limit of Liability per [on-premises Felonious Assault Coverage][, On-Premises Terrorism Coverage][, War Risk Coverage][, on-premises Bomb Scare/Explosion Coverage] Covered Accident [combined] is [$0.00].

[Aggregate Limit of Liability does not apply.]

C. HAZARD(S)

[All Classes]	[24 Hour Accident Protection, Business and Pleasure, Excluding Corporate Owned or Leased Aircraft]
[Class 1]	[24 Hour Accident Protection while on a Specified Trip]

D. ADDITIONAL COVERAGE(S)

[All Classes]	[Exposure and Disappearance Coverage]
[Class 2]	[Felonious Assault Coverage]

E. BENEFITS

- Accidental Death Benefit with a [365] day incurral period

  Benefit equals **[**100%] of Principal Sum

  Applies to [all Classes of Primary Insured Persons][Class 1][Classes 2 and 3]

- [Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit with a [365] day incurral period

  Applies to [all Classes of Primary Insured Persons][Class 1][Classes 2 and 3]

Covered Loss of:	**Benefit**
Both hands or both feet	[100%] of Principal Sum
One hand and one foot	[100%] of Principal Sum
One hand or one foot plus sight of one eye	[100%] of Principal Sum
Sight of both eyes	[100%] of Principal Sum
Speech and hearing	[100%] of Principal Sum
Speech or hearing	[50%] of Principal Sum
One hand or one foot or sight of one eye	[50%] of Principal Sum
Thumb and index finger of the same hand	[25%] of Principal Sum

[Covered Loss of Use of:	
Four Limbs	[100%] of Principal Sum
Three Limbs	[75%] of Principal Sum
Two Limbs	[66 2/3%] of Principal Sum
One Limb	[50%] of Principal Sum]]

	Benefit
- [Coma Benefit with a [365] day incurral period	[1%] of Principal Sum for up to [100] months

  Applies to [all Classes of Primary Insured Persons][Class 1][Classes 2 and 3]]

F. ADDITIONAL BENEFITS

	Benefit
♦ [Seat Belt Benefit	[10%] of Principal Sum to maximum of [$10,000]
Applies to [all Classes of Primary Insured Persons][Class 1][Classes 2 and 3]]	
♦ [Higher Education [(with Dependent Coverage only)]	[5%] of Principal Sum to maximum of [$5,000] for up to [4] consecutive years
Applies to [all Classes of Primary Insured Persons][Class 1][Classes 2 and 3]]	
♦ [Spouse Retraining [(with Dependent Coverage only)]	actual cost incurred in [24] months to maximum of [$3,000]
Applies to [all Classes of Primary Insured Persons][Class 1][Classes 2 and 3]]	
♦ [COBRA	lesser of [5%] of Principal Sum, [$5,000], or actual cost of [1] year of medical coverage]
Applies to [all Classes of Primary Insured Persons][Class 1][Classes 2 and 3]]	
♦ [Day Care (with Dependent Coverage only)	lesser of actual cost, [3%] of Principal Sum, or [$3,000] for up to [4] consecutive years
Applies to [all Classes of Primary Insured Persons][Class 1][Classes 2 and 3]]	
♦ [Home Alteration/Vehicle Modification	[10%] of Principal Sum to maximum of [$10,000]]
Applies to [all Classes of Primary Insured Persons][Class 1][Classes 2 and 3]]	
♦ [Rehabilitation	lesser of actual cost incurred in [2] years or [10%] of Principal Sum to maximum of [$10,000]
Applies to [all Classes of Primary Insured Persons][Class 1][Classes 2 and 3]]	
♦ [	[ ]]

G. PREMIUM

Due Date: [15th day of month following month of coverage] [First day of each month]
[Effective date of Policy] [as indicated below]

Amount Due:

[Employee Only:	[$0.000] per $[1,000] of Principal Sum per month]
[Spouse[/Domestic Partner] Only:	plus [$0.000] per $[1,000] of Principal Sum per month]
[Dependent Children Only:	plus [$0.000] per $[1,000] of Principal Sum per month]
[Employee & Dependents:	[$0.000] per $[1,000] of Principal Sum per month]
[Continuation of Coverage - Employee Only:	[$0.000] first annual premium]
[Continuation of Coverage - Employee & Dependents:	[$0.000] first annual premium]
[Annual Premium Option:	[$10,000]]
[Multiple Years Option:	[$150,000] [three] year term premium payable in equal annual installments: [$50,000] due [January 1, 2007] [$50,000] due [January 1, 2008] [[$50,000] due [January 1, 2009]]]

[Multiple Years Prepaid Option:	[$150,000] [three] year term premium payable in advance
[Additional Specified Pilot Coverage Premium:	[$0.00] per [$1,000] of Principal Sum per month while a pilot, operator, crew member or cabin attendant]]
[War Risk Coverage Premium:	[included in Premium stated above][$50,000] [[$5,000] per [month]]

[Guarantee: [These rates are][This Policy is] guaranteed until [January 1, 2009].]
[These rates and this Policy are guaranteed until [January 1, 2009].]]

- **[CORPORATE CONTACT INFORMATION FOR TRAVEL ASSISTANCE**

(This information is to be used only for notification when travel assistance medical services are utilized and for employee and/or family member eligibility verification. Information should provide access to contacts on a 24-hour emergency basis only.)

Primary Contact Name:_____	Secondary Contact Name:_____
Title: _____	Title:_____
E-Mail Address: _____	E-Mail Address:_____
Business Telephone: _____	Business Telephone:_____
Home Telephone: _____	Home Telephone: _____
Cell Phone: _____	Cell Phone: _____
Address (if different from above):	Address (if different from above):
_____	_____
_____	_____]]

- **[FRAUD STATEMENT**

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

The undersigned declares that:

All information provided in this Application and any attachments hereto is true and correct. The undersigned understands that all information provided in this Application and any attachments hereto is material to Atlantic Specialty Insurance Company's decision to provide this insurance, and that insurance will be provided, at Atlantic Specialty Insurance Company's sole discretion, in reliance upon the truth of such information.

It is hereby understood and agreed that:

1. this insurance is provided by Atlantic Specialty Insurance Company in consideration of payment of the required premium;
2. the insurance under the Policy begins on the Policy Effective Date shown above [; and
3. the acceptance of the Policy terminates any prior Policy of the same Policy number, effective with the inception of the Policy].

Name of Policyholder: _____

Signature of Authorized Person: _____ Title: _____

Print Name: _____Date:_____

OneBeacon
INSURANCE

Date: August 23, 2011

To: State Insurance Departments

From: Dennis R. Smith

Subject: Filing Authority for Coulter & Associates, Inc.

I, Dennis Smith, an officer of Atlantic Specialty Insurance Company, have authorized Coulter & Associates, Inc., acting as our Contracts Consultants, to file products and correspond with your Department on our behalf.

This Authorization is effective until August 31, 2012.

Officer Signature: 

Title: Secretary

TO: Commissioner of Insurance
Arkansas Insurance Department

RE: Atlantic Specialty Insurance Company

RULE AND REGULATION 19 CERTIFICATION

This is to certify that the referenced certificate of coverage form complies with the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

Signed for Atlantic Specialty Insurance Company by

9/6/2011
Date

Signature

Keith Firestone, Assistant Secretary
Typed Name and Title